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Substance Use and Pregnancy: Conceiving Women in the Policy-Making Process

Deborah Rutman, Marilyn Callahan, Audrey Lundquist, Suzanne Jackson and Barbara Field

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Deborah Rutman, Marilyn Callahan, Audrey Lundquist,
Suzanne Jackson and Barbara Field

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August 2000

Status of Women Canada is committed to ensuring that all research produced through the Policy Research Fund adheres to high methodological, ethical and professional standards. The research must also make a unique, value-added contribution to current policy debates, and be useful to policy makers, researchers, women's organizations, communities and others interested in the policy process. Each paper is anonymously reviewed by specialists in the field, and comments are solicited on:

- the accuracy, completeness and timeliness of the information presented;
- the extent to which the analysis and recommendations are supported by the methodology used and the
- data collected;
- the original contribution that the report would make to existing work on this subject, and its usefulness
- to equality-seeking organizations, advocacy communities, government policy makers, researchers and other target audiences.

Status of Women Canada thanks those who contributed to this peer review process.

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PREFACE

Good public policy depends on good policy research. In recognition of this, Status of Women Canada instituted the Policy Research Fund in 1996. It supports independent policy research on issues linked to the public policy agenda and in need of gender-based analysis. Our objective is to enhance public debate on gender equality issues in order to enable individuals, organizations, policy makers and policy analysts to participate more effectively in the development of policy.

The focus of the research may be on long-term, emerging policy issues or short-term, urgent policy issues that require an analysis of their gender implications. Funding is awarded through an open, competitive call for proposals. A non-governmental, external committee plays a key role in identifying policy research priorities, selecting research proposals for funding and evaluating the final reports.

This policy research paper was proposed and developed under a call for proposals in April 1997 on *the integration of diversity into policy research, development and analysis*. While it is recognized that women as a group share some common issues and policy concerns, women living in Canada are not a homogeneous group. Aboriginal women, women with disabilities, visible minority women and women of colour, linguistic minority women, immigrant women, lesbians, young women, poor women, older women and other groups of women experience specific barriers to equality. Through this call for proposals, researchers were asked to consider these differences in experiences and situations when identifying policy gaps, new questions, trends and emerging issues, as well as alternatives to existing policies or new policy options.

Status of Women Canada funded six research projects on this issue. They examine the integration of diversity as it pertains to issues of globalization, immigration, health and employment equity policies, as well as intersections between gender, culture, education and work. A complete list of the research projects funded under this call for proposals is included at the end of this report.

We thank all the researchers for their contribution to the public policy debate.

TABLE OF CONTENTS

ABSTRACT i

EXECUTIVE SUMMARY iii

PREFACE ix

CHAPTER 1: BACKGROUND THOUGHTS FROM LITERATURE AND POLICY 1

Introduction 1

Thoughts from the Literature 1
- Substance Use and Women 2
- Substance Use During Pregnancy 5
- Debates on Punishing Women and Protecting Children 8

Policy and Policy Making 9
- Policy Context – National 11
- Canada's Aboriginal Policy 11
- Drug Policy 12
- Health Policy 14
- Canada's Criminal Code 15
- Provincial Policy Context 16
- Mental Health Acts 16
- Child Protection 18
- Addiction Treatment Services 21
- Provincial Initiatives 22

CHAPTER 2: AN ANALYSIS OF THE SUPREME COURT DECISION IN THE CASE BETWEEN WINNIPEG CHILD AND FAMILY SERVICES AND MS. G. 25

Introduction 25

Research Methods 25

The Legal Argument as a Process for Constructing Problems and Solutions 27

The Data and Analysis of the Factums 29
- The Statement of Facts 29
- The Points in Issue 31
- The Argument: Defining the Problem 32

The Argument: Defining the Solution 34
Summary of the Factums 36

The Data and Analysis of the Supreme Court Decision 36
Connecting Addictions and Fetal Harm 37
Addictions are a Lifestyle Choice 39
About Addictions Treatment and the Benefits of Mandatory Intervention 41
About First Nations Peoples and Women 41
About Fetal Rights 43
About Women's Rights 44

Concluding Remarks 44

CHAPTER 3: MISCONCEIVING MS. G.: A CRITICAL DISCOURSE ANALYSIS OF THE CANADIAN PRINT MEDIA'S COVERAGE OF THE CASE OF MS. G. 47

Introduction 47

Research Methods 47

Presentation and Analysis of the Data 49
What Aspects of the Supreme Court Decision are Highlighted? 49
What Does the Media Report from the Majority and Minority Judgments? 52
Supreme Court Majority's Arguments 52
The Majority's Framing of the "Problem" and the "Solution" 54
Supreme Court Minority's Arguments 56
The Minority's Framing of the "Problem" and the "Solution" 56
Editorials' and Commentaries' Framing of the "Problem" and the "Solution" 59

How is Ms. G. Depicted in the Print Media? 62
News and Editorial Articles' Depiction of Ms. G. 64

What is Said in the Media About Substance Addiction Issues? 69
What is Not Discussed in the Media's Coverage? 70
What is Said in the Media About Aboriginal Issues? 71
Who is Cited and What is Missing from the Media's Coverage? 72

CHAPTER 4: POLICY IMPACTS PART I – Perspectives of Substance-Using Women, Aboriginal Women and Human Service Practitioners PART II – Aboriginal Women Speak Out 73

Part I 73

Introduction 73

Context: Profile of Substance-Using Pregnant Women 74

Ideological Underpinnings of Policy and Practice 77
Predominance of an Abstinence Model 78
The Effects of Abstinence Models and Ideology 78
The Assumption/Ideology that Parents Who Use Substances are Bad Parents 79
Effects of Assumptions and Ideology that Parents Who Use Substances are Bad Parents 80
Predominance and Effects of Dichotomous Thinking in Relation to Child Welfare Policies: Child vs. Family Focused 83
Predominance and Effects of Stereotyping, Homogenizing and Ghettoizing Women Who Use Substances 84

Policy Disconnections and Disjunctions 85
Disconnections Between Policies in Different Arenas 85
Women are Set Up for Failure 86
People are Punished for Their Substance Use 86
Lack of Coordination and Communication in the Family Health Field 87
Workers Experience Role Confusion and Frustration 87
Women Avoid Accessing Treatment 88
Addictions-Related Training is Insufficient 88

Scarcity of Treatment Resources and Options for Pregnant or Parenting Women 89
(In)appropriateness of Existing Resources 89
Effects of Inappropriate Treatment Options: Women Drop Out 90
(Un)timeliness of Existing Resources 90
Effects of Untimely Resources: Windows of Opportunity are Lost 91
(In)accessibility of Existing Resources 92

Ideologies in Transition: The Process and Effects of Implementing a Harm-Reduction Model 92

Conclusion: Implications of Treatment Resourcing for Child Protection 94

Part II 95

Introduction 95

Why Women May Use Substances During Pregnancy 96
Substance Use as a Learned Behaviour 96
Impact of Residential Schools and the Apprehension of Children: Loss of Culture and Low Self-Esteem 97
Impact of Childhood Physical and Sexual Abuse 98
Lack of Knowledge About Harmful Effects of Substance Use During Pregnancy 98
Substance Use in Unwanted Pregnancies 99
The Power of Substance Addiction 99
Barriers to Aboriginal Women's Treatment and Recovery 100

Aboriginal Perspectives on Mandatory Treatment/Confinement for Pregnant Women Who Use Substances **102**
- Distinguishing Between Mandatory Treatment and Mandatory Confinement 103
- Multiple Perspectives – Divided Opinions 103
- In Support of Mandatory Confinement 104
- Mandatory Confinement within an Aboriginal Context 105
- In Opposition: Mandatory Treatment/Confinement as a Means to Further Oppress Aboriginal People 105
- Mandatory Treatment/Confinement as Potentially Harmful to the Fetus 106

Key Excerpts from One Focus Group Discussion on Mandatory Treatment/Confinement **107**

CHAPTER 5: CASE STUDY: AN ABORIGINAL NATION'S EFFORTS TO ADDRESS SUBSTANCE USE DURING PREGNANCY **111**

Part I **111**

Background **111**
- Purpose of the Case Study and Research Questions 111
- The Researchers 111
- The Reasons for the Case Study 112
- The Research Approach 115

Part II **116**

The Case Study **116**
- The Participants 117
- The Broad Government Policy Context 118
- A Community in Transition 119
- Self-Government 121
- A Community Healing Centre 122
- Health Systems 123
- Child Welfare 123
- Cultural Approaches to Community Issues 124

Women in the Community Respond to Substance Use During Pregnancy **126**

Community Messages About Women and Substance Use During Pregnancy **128**

Issues of Concern **130**

Input from Women and Youth into Overall Policy and Decisions Affecting Their Daily Lives **130**
- Rejuvenating Culture and Reforming Structures 131
- Putting the Issues on the Table and Managing Conflict 132
- Leadership During a Time of Change 133

Building Resources 135

Taking the Next Steps **135**
A Cultural Development Centre 136
A Place for Women 136
A Traditional Gathering: A Gitxsan Think Tank 137

Conclusion **137**

CHAPTER 6: RESPONSES TO SUBSTANCE USE DURING PREGNANCY: ALTERNATIVES AND RECOMMENDATIONS 139

Introduction **139**

Part I **139**

Directions From Substance-Using Women, Human Service Practitioners and Aboriginal Women **139**
Alternative Ideologies and Attitudes 139
Shift from Abstinence to a Harm-Reduction Philosophy 140
Shift from Child Welfare/Protection Ministry as Adversarial to the Ministry as Supportive 140
Shift from Viewing Child Apprehension as the Failure of an Individual Family to a Failure of the System/Society 140
Community Awareness and Education 141

Effective Treatment Approaches – What Works from the Perspective of Women **141**
Treatment Programs Geared Specifically for Pregnant Women 142
Programs and Facilities for After Care 142
Wholistic Care 143
Outreach 143
Residential Facilities with Home-Like Environments 144
Peer Support, Counselling and Group Work 144
Non-Judgmental Attitudes of Practitioners and Unconditional Support 144
Individualized Treatment Plans Made Collaboratively with Women 145

Healing Through Cultural Renewal – What Works from the Perspective of Aboriginal Women **146**
Supporting Aboriginal Women to Take Leadership Roles Within Communities 147

Alternative Policy Development Processes **148**
The Sheway Project – Downtown East Side, Vancouver 148
Breaking the Cycle – Toronto 149
FAS Community Collaborative Network – Prince George 150

Part II **151**

Directions from the Supreme Court Decision **151**
Supreme Court Majority Judgment 151
Our Response 151
Supreme Court Minority Judgment 151
Our Response 152

Recommendations **153**

BIBLIOGRAPHY **155**

SUBSTANCE USE AND PREGNANCY: CONCEIVING WOMEN IN THE POLICY-MAKING PROCESS

Abstract

Deborah Rutman, Marilyn Callahan, Audrey Lundquist,
Suzanne Jackson and Barbara Field

This report examines how policy in Canada deals with the issue of substance use during pregnancy and suggests alternative ways of addressing this problem that may prove less polarizing and punitive toward women. One focus of this project has been to analyse the Supreme Court of Canada case of Ms. G. (October 31, 1997), in which a judge ordered mandatory drug treatment for a young, low-income Aboriginal woman who was addicted to sniffing solvents; both the Majority and Minority judgments and the media coverage of the case were examined through a discourse analysis. Another important component of the project has been to uncover the experiences of substance use, pregnant women and the practitioners who work most closely with them, and to hear their ideas about approaches that make a positive difference. A final and important component has been an in-depth case study, carried out in one Aboriginal community to determine approaches that have a chance for success in that community. The project has also aimed to address the challenge of integrating diversity into policy research, development and analysis. Our project resulted in a number of important directions for policy and practice, and our report concludes by providing a set of recommendations grounded in the experiences of the people directly affected by the issues, which, we submit, will help ensure the proposed directions' relevance and ultimate success.

SUBSTANCE USE AND PREGNANCY: CONCEIVING WOMEN IN THE POLICY-MAKING PROCESS

Executive Summary

Project Aims

This report examines how policy in Canada deals with the issue of substance use during pregnancy and suggests alternative ways of addressing this problem that may prove less polarizing and punitive toward women. One focal point has been the Supreme Court case of Ms. G., in which a judge ordered mandatory drug treatment for a young, low-income Aboriginal woman who was addicted to sniffing solvents and who sniffed glue during her pregnancy. This research project also aims to address the challenge of integrating diversity into policy research, development and analysis.

Research Questions and Methods

Questions guiding the research were:

- What specific policy initiatives exist and have been used to address the problem of substance use and pregnancy?
- How has substance use by women during pregnancy been framed as a policy concern, as evidenced by discourse in Canadian jurisprudence, policy/practice literature and the media?
- What are the perceived effects of existing policy from the standpoint of Aboriginal women, substance-using women and human service professionals?
- What policy alternatives exist or could be developed that do not replicate the familiar dichotomies in the current policy discourse?

These questions were addressed using a range of qualitative research methods, including a literature and policy review and analysis, a discourse analysis of the Supreme Court decision and the media coverage on the case, individual interviews and focus groups with human service workers and substance-using women (Aboriginal and non-Aboriginal), and a case study based on participant observations, interviews and focus groups.

Our research process has been collaborative. Our multi-disciplinary project team has been a diverse group, representing Aboriginal and non-Aboriginal backgrounds, academic and non-academic locations, and a mix of ages, incomes and experiences. Nevertheless, all members of the team are mothers and share a common interest, albeit for a variety of reasons, in the issues related to substance use by women during pregnancy.

Key Findings

Substance-using women, human service practitioners and Aboriginal women identified important directions for policy and practice which we fully support and which we present below. Policy alternatives uncovered through our analysis of the Supreme Court decision and the media discourse are also discussed and evaluated. Finally, we conclude by providing a set of recommendations directed to the federal government and to Status of Women Canada. We submit that these policy recommendations are grounded in the experiences of the people directly affected by the issues, which will help ensure the recommendations' relevance and ultimate success.

Paradigm Shifts

Participants spoke of three major ideological shifts that are critical to ensure effective policy and program development. These ideological shifts are:

- from a moralizing/medical model to a harm-reduction/health promotion philosophy;
- from child welfare mandate as protection-focused to one that emphasizes supporting families; and
- from viewing child apprehension as the failure on the mother's part to a failure of the system/community to provide what is needed.

In addition, community awareness and education were seen as key prevention strategies. Children and youth need to be informed about the effects of maternal substance use, fetal alcohol syndrome and fetal alcohol effect, and about reproductive health and birth control. Participants also emphasized the importance of openly discussing the *causes* of (maternal) substance use, particularly within an Aboriginal context.

Effective Treatment Approaches – What Works from the Perspective of Women

Effective treatment addresses the barriers that women have in accessing care. These barriers, as identified by women themselves, include:

- fear of the baby's apprehension by child welfare authorities;
- contradictions between abstinence and harm-reduction approaches;
- contradictions between addictions and child protection ideologies;
- lack of fit between existing treatment options and pregnant women's needs;
- lack of availability of treatment when women seek it or need it ;
- inflexible rules and inaccessible care;
- unsupportive attitudes of practitioners;
- lack of training for practitioners who could help in accessing care; and
- lack of resources that enable women to get to treatment.

These barriers are largely due to disconnections between policies and/or to incongruities in the ideologies that underpin policies. Thus, successfully addressing the barriers will require policy *integration*. Moreover, the integration process should be informed by a thorough appreciation of how current policies affect women.

In addition, participants identified a number of key dimensions of effective treatment approaches. These are:

- treatment programs geared specifically for pregnant women;
- programs/facilities for after care;
- wholistic care;
- outreach;
- residential facilities with home-like environments;
- peer support, counselling and group work;
- non-judgmental attitudes of practitioners and unconditional support; and
- individualized treatment plans made collaboratively with women.

Healing Through Cultural Renewal

Aboriginal women spoke of the tremendous importance of cultural (re)connection as a means to facilitate healing and support recovery. Reconnection with traditional culture instils or restores feelings of self-respect, pride and identity that may have been all but extinguished. In addition to being a key to recovery, connecting with traditional culture can be a means to *prevent* substance use among Aboriginal people, especially youth.

Our Response to Mandatory Treatment/Confinement

Our project's findings indicate that mandatory treatment/confinement or other punitive/coercive types of approaches are not appropriate policy directions in Canada for a number of reasons:

- The evidence is overwhelming that blaming and shaming individual women for their substance use and addiction problems does not work. Indeed, social reprobation and stigmatization accelerate downward cycles and hamper healing and recovery.
- Designing and implementing mechanisms for mandatory treatment/confinement would consume precious public resources that more appropriately ought to be dedicated toward community-based prevention initiatives.
- Mandatory treatment/confinement reproduces and reinforces the oppression that contributes to women's substance use in the first place.
- Good policy cannot be made in a knowledge vacuum. There presently is a dearth of knowledge about the life experiences of "those women" who use substances during pregnancy. In addition, scientific knowledge is still incomplete with regard to the likelihood, nature and irreparability of fetal harm ensuing from maternal substance use.
- Mandatory treatment/confinement singles out and punishes individual women, without recognizing our collective, societal responsibility to promote and ensure healthy fetal development.

Recommendations

1. We recommend that federally funded, community-driven initiatives such as the Community Action Plan for Children be continued and expanded in order to ensure local projects' continuity, and to increase the number of community-based projects and programs that respond to local needs.

2. We recommend that federal resources be allocated to establish and provide infrastructure support to local/provincial "Policy Round Tables." These Tables would serve to promote public awareness of the multiple and complex issues connected to substance use during pregnancy, and would aim to identify a set of "common ground" principles to underpin comprehensive policy development. Key attributes of these Policy Round Tables include: collaborative, inclusive, locally focused, ongoing and wholistic.

   As an initial component of their work, we recommend that these Policy Round Tables audit existing resources for pregnant/parenting women who use substances. This will identify the barriers and enablers to effective treatment and therefore help develop appropriate policies and approaches.

3. We recommend that the federal government allocate resources to strengthen the capacity of traditionally marginalized constituencies – in particular, Aboriginal communities – to enable them to participate with a strong voice at the Policy Round Tables. In addition, we recommend that federal funds be allocated for grass-roots communities to create the infrastructure needed to implement the directions of the Policy Round Tables.

4. We recommend that government allocate funding for participatory action research in Aboriginal communities, and that this research be overseen and undertaken by Aboriginal people. Aboriginal people need to have increased opportunities to create solutions that are community-responsive and community-controlled. Moreover, we recommend that Status of Women Canada make the funding of participatory action research in Aboriginal communities a high priority in its research agenda.

5. Participants spoke clearly about existing barriers to treatment and recovery, and they identified numerous critical dimensions of effective care and support. Participants' ideas constitute a body of recommendations for policy and practice that we fully endorse. In addition, we underscore three interrelated recommendations that emerged from participants' messages:

   - that government ensures that adequate resources for *women-centred* alcohol and drug treatment programs are available;
   - that, through the ongoing Policy Round Table process, disconnections and incongruities in existing policies and approaches are identified and addressed; and
   - that health promotion and harm-reduction philosophies be the starting point for policy discussions and proposed remedies in relation to pregnant women who use substances.

6. Finally, we strongly recommend that government place a moratorium on legislating policy that allows for mandatory treatment or confinement for pregnant women who use substances. This moratorium should be in effect until all other options, particularly those recommended here, have been exercised and evaluated.

PREFACE

Aims and Rationale

This report examines how policy in Canada deals with the issue of substance use[1] during pregnancy and suggests alternative ways of addressing this problem that may prove less polarizing and punitive toward women. This purpose is by no means a simple one. There are many competing points of view about appropriate policy directions, and these views are deeply held and difficult to change. Yet at the same time, many other voices have not been heard in this debate, particularly women who are addicted to substances during pregnancy and those who work most closely with them. This report examines a wide range of perspectives and suggests ways in which many of these perspectives can be accommodated within particular policy directions.

The project arose from the case of Ms. G. and Winnipeg Child and Family Services (Northwest Area). In August 1996, a judge of the Manitoba court of Queen's Bench ordered that Ms. G. be detained in a health care facility because of concern about her mental competence. Ms. G. was pregnant and frequently sniffed solvents, a practice that was deemed potentially harmful to the fetus. The decision was quickly set aside on appeal. Winnipeg Child and Family Services later appealed to the Supreme Court of Canada. After hearing many briefs on the matter from a wide variety of interest groups and after considering the legal issues in the case, the Supreme Court upheld the appeal court decision, issuing a lengthy judgment released on October 31, 1997, with both a Majority and Minority report.

On one hand, the Supreme Court decision could be seen as a victory for those opposed to infringement of the rights of women. But the wretched circumstances of a pregnant woman addicted to solvents were not addressed by the decision. Nor did the decision alleviate the desperation of social workers and a provincial court judge who felt compelled to act in this unusual fashion.

As researchers, we were concerned that the case would become something of a watershed in Canada regarding the issue of substance use and pregnancy. It received national media coverage, much of it pitting a woman's rights against the well being of her fetus. It coupled this unsympathetic portrayal of women with the notion that there was no other course of action in such situations and that those acting "for the fetus," while confounded by law, were morally right. Rather than open up discussion of the problem and other avenues for action, media coverage encouraged Canadians to choose one side or another. The situation was ripe for another case to be identified and tried again, particularly since several states in the U.S. have passed various pieces of legislation aimed at incarcerating pregnant women who use substances.

Public discussion of this particular case did not highlight its important realities. Ms. G. was a First Nations woman who had been in the care of government as a child and had lived in stark poverty most of her adult life. We were concerned that public discussions that ignored these factors would produce policies that further harmed low-income First Nations women, directing scarce resources into programs designed to detect their substance use and punish them for it. A related area, child welfare, has always been plagued by such an imbalance. While it espouses prevention of child abuse and neglect and aims to support families, most expenditures in child welfare programs are directed at determining whether parents have neglected their children, taking court action against some of these parents and providing alternative care for their children. Developing incarceration policies for pregnant women would inevitably create the same kind of system.

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[1] Throughout this report we have chosen to adopt a value-neutral stance in relation to women's substance use during pregnancy. Our choice reflects our bias toward a harm-reduction approach to this problem. We feel that the terms "abuse" and "misuse" tend to imply some amount of judgment toward the woman and encourage an avenue of thinking that separates her from the context of her life.

Thus, as researchers, we began the project committed to listening to those who had not been heard in the recent debates and finding ideas for policy making that moved beyond the unproductive debate of mothers' rights or fetus' rights.

Research Methods

The questions that guided our research were the following:

- What specific policy initiatives exist and have been used to address the problem of substance use among pregnant women?
- How has substance use by women during pregnancy been framed as a policy concern, as evidenced by discourse in Canadian jurisprudence, policy/practice literature and the media?
- What are the perceived effects of existing policy from the standpoint of Aboriginal women, substance-using women and human service professionals?
- What policy alternatives exist or could be developed that do not replicate the familiar dichotomies in the current policy discourse?

These questions were addressed using a range of qualitative research methods, including a literature and policy review and analysis, discourse analyses of the Supreme Court Majority and Minority decisions and the media coverage of the case, individual interviews with human service workers and substance-using women (Aboriginal and non-Aboriginal), focus groups with the aforementioned, a case study based on participant observations and interviews and focus groups within a northern Aboriginal community, and a thematic analysis of the data gathered.

This research has been undertaken by a group of five researchers working part-time between December 1997 and February 1999. We are a diverse group, representing Aboriginal and non-Aboriginal backgrounds, academic and non-academic locations, and a mix of ages, incomes and experience. All of us are mothers and share a common interest, albeit for a variety of reasons, in the issues related to substance use by women during pregnancy.

Outline of the Report

This report has been prepared by two teams: one composed of First Nations researchers and the other of non-Aboriginal women. We deliberated over how to produce a report that genuinely reflects the indivisible issues that face women who use substances during pregnancy, and the distinct issues experienced by Aboriginal women. We recognized that Aboriginal women face particular challenges, largely created by a longstanding web of conflicting and detrimental policies of various levels of government. Moreover, Aboriginal women had been largely left out of the policy debates thus far and we believed it was important to feature their opinions prominently. In the end, we decided to prepare one report that provides several sections on Aboriginal perspectives.

The report has six chapters, followed by a reference section and an appendix:

Chapter 1: Background Thoughts from Literature and Policy. This literature and policy review provides background information on substance-using pregnant women and on existing Canadian policy, including Aboriginal policies.

Chapter 2: An Analysis of the Supreme Court Decision in the Case of Ms. G. This is a discourse analysis of the Supreme Court decision, including the Majority and Minority report. One intent of this report is to analyse more fully what the court decision actually said, the differences of opinion between the Majority and Minority reports, areas where the two opinions agreed, and what issues were not discussed in the decision. We hoped to extract from this analysis the opinions of the court in the policy options that would be proposed.

Chapter 3: Misconceiving Ms. G. – A Critical Discourse Analysis of the Canadian Print Media's Coverage of the Case of Ms. G. This chapter presents a discourse analysis of the press coverage of the Supreme Court decision. National and local press coverage is analysed with a view to determining how the debates in the press squared with the actual decision of the Supreme Court, what new issues and voices were included in the debate, who was left out, and what ideas emerged that contribute to and impede new policy ideas.

Chapter 4: Policy Impacts. Part I of this chapter presents a study of women who are affected by substance use during pregnancy and those who work closely with them. As noted above, these voices have particular expertise in this issue but are rarely heard in the policy debates. This chapter compiles their views on the nature of the problem, identifies the policies that hinder and help, and presents ideas for the future. The views of First Nations women are presented in Part II of this chapter. Although many views of First Nations and non-First Nations women overlap, those of First Nations women reflect a unique experience that is distinct and is too often lost in the mainstream reporting of women's experience. For this reason we have chosen to report their thoughts in this manner.

Chapter 5: Case Study – An Aboriginal Nation's Efforts to Address the Issue of Substance Use During Pregnancy. This case study chronicles an Aboriginal community and its views on substance use, pregnancy, government policy making and community challenges. This report connects the issues of substance use and pregnancy with the history of government attempts to colonize First Nations people, including present-day efforts that further impede First Nations people in their quest for healing and self-government. It examines the views of one particular community in Canada, a northern nation in British Columbia, and the struggles of community members to take hold of this issue. These experiences point to directions for substantial reform.

Chapter 6: Responses to Substance Use During Pregnancy – Alternatives and Recommendations. This chapter presents directions for policy and practice as articulated by substance-using women, the human service professionals who work with them, and by Aboriginal women and community members. We then review and respond to the policy alternatives uncovered through our analysis of the Supreme Court decision and the media discourse. We conclude by providing a set of recommendations directed to the federal government and to Status of Women Canada.

Bibliography: A bibliography that includes references on women's substance use, pregnancy and substance use, and policy making.

CHAPTER 1: BACKGROUND THOUGHTS FROM LITERATURE AND POLICY

By Barbara Field

Introduction

As noted in the preface to this report, our inquiry arose from the Supreme Court case regarding the situation of Ms. G., a young Aboriginal mother who continued to sniff solvents during her pregnancy and who community child welfare workers felt unable or unequipped to help. Winnipeg Child and Family Services requested assistance from the courts to involuntarily secure Ms. G. in treatment when they felt that all persuasive avenues were exhausted. Thus, a series of court hearings and appeals began, framed within the adversarial system of Canadian jurisprudence. The analysis of these proceedings and the media coverage it garnered is presented elsewhere in this report; however, it is important to note here that for the purpose of addressing this question, the Supreme Court Justices reconfirmed their previous decisions – the fetus is not a person with rights in law. They referred the business of determining approaches to this serious societal concern, however it may be characterized, to the legislature.

This chapter will:

- review the literature on substance use, women and pregnancy, with a particular focus on examining the ideological underpinnings that emerged through the analyses of the Supreme Court decision and the media coverage of Ms. G.'s case; and
- discuss social policies that directly target or indirectly influence responses to women who use substances while pregnant.

Thoughts from the Literature

Literature in the area of women with substance-use problems, and more particularly pregnant women and substance use, was reviewed to:

- understand how the issue has been framed;
- provide a context for how the different ideologies revealed through the discourse analyses of the Supreme Court case and its media coverage had been generated; and
- to determine how various policy issues were described.

Although we looked for literature that was specific to Aboriginal women's struggles with pregnancy and substance use, such material was extremely difficult to find. In reviewing the literature on pregnancy and substance use, it quickly became apparent that material written from the perspective of women who have lived this experience is also not readily available. Instead there is a large body of literature written by professionals for professionals, primarily to suggest how to identify and treat this population of women.

Substance Use and Women

Questions have arisen about the applicability of mainstream, predominant theories of addiction to women and minorities. Feminists examining the literature argue that before the 1970s there was very little material on substance use that addressed women's particular issues with substance use and treatment needs in this area:

> Prior to the 1970s there existed virtually no research on women with substance use problems and virtually no gender specific treatment programming. Since the 1970s there has been a steady increase in both the quantity and quality of research on women as well as a growth in specialized women's programming. However, women continue to be underserved in both prevention and treatment programs and information remains scarce in many areas (Poole, 1997, p. 2).

Abbott (1994) suggests that since our health care system and larger society have been defined by male interests, it is not surprising that addiction was identified and developed from a male standpoint. She attributes the burgeoning interest in women as a separate category of substance user to the feminist movement, researchers and service providers, who recognized deficits in the system, "or some males' concern about the limitations substance abuse can place on a woman's role in human reproduction and parenting" (ibid., p. 70).

In a historical review of the research literature, spanning five decades on women and alcoholism, Clemmons (1985) found that the literature reflected the social thought of the particular period in which the research was carried out. She suggests that while the studies of the first few decades focused on the individual psychopathology of women (suggesting in the 1930s that women who were diagnosed as alcoholics were more deviant than men), the prevalence and incidence studies of the 1950s began to reflect a shift toward a more social model. Treatment for women became of interest in the 1960s, and in the 1970s Clemmons found two predominant themes in the literature – sexual promiscuity and Fetal Alcohol Syndrome (FAS). "Each of these topics led to moral censure of the female alcoholic rather than the investigation of a social issue" (Clemmons, 1985, p. 78).

Suzanne Ostermann (1995) argues that all basic treatment services are rooted "in two distinct movements: the founding of Alcoholics Anonymous (AA) in 1935 and the creation of [the] Synanon Foundation in 1958" (p. 5). She claims that the AA 12-step program is the forerunner of today's peer support, self-help and recovery home models, and the structure and psycho-analytic orientation of Synanon formed the genesis of the residential treatment and therapeutic communities that are an integral part of current recovery approaches. She adds, however, that "many feminists see the recovery movement as represented by these pioneering programs and their offspring, as pathologizing the effects of the socialization of women in our culture" (Ostermann, 1995, p. 5).

Women's advocates have argued that women have needs in addiction treatment that are distinct from men's needs, and that women's substance use patterns need to be understood in relation to a number of key contextual issues. These include "low self esteem, stigmatization, high incidence of physical and/or sexual abuse as a child, lack of social support, need for social services and child care, need for support and education around parenting, relationship counselling, coping skills training, and vocational and legal assistance" (Kearney, 1997, p. 463). Substance-use patterns are influenced by a partner's substance use, social isolation, stressful life events such as a death in the family, and the challenges of living in poverty (Poole, 1997).

Not only are women's distinct treatment needs ignored by models that originated in response to male issues and understandings of addiction, the confrontational approaches that are predominant in them are contraindicated for women.[1] Ostermann (1995) suggests that the AA tenet of service, for example, is not useful to women who lack in self-esteem. Women who have typically spent their lives serving others need to develop a healthy sense of self that can say "no." Bill White's (1998) findings over the past two decades in the addictions field also support the belief that women respond to different approaches than men. He suggests that the models based on empowered white men exclude many individuals, particularly those who have traditionally not been in dominant, privileged positions in society. One cannot wait for women with extensive histories of victimization to "hit bottom," a primary concept of much traditional treatment:

> ...these women's capacity for physical and psychological pain is almost limitless. If we wait for them to hit bottom they will die. The issue is not an absence of pain in their lives. They have more pain than most of us can even comprehend. The issue is an absence of hope. Now that is a radical rethinking of how people are motivated to enter the recovery process" (White, 1998, p. 6)

White (1998) challenges another historical tenet of treatment, arguing that newer and evolving women-centred models must increase women's sense of powerfulness, rather than employ more traditional strategies such as family interventions. This is because "if you escalate pain where there's no pre-existing foundation of hope, not only do you not spark this wonderful transformative experience, what you actually do is increase the risk of self-destructive behaviour and flight" (p. 6). *The Hidden Majority* (1996) suggests that women-centred approaches blend a number of theoretical approaches[2] about addiction in an effort to provide comprehensive treatment that can respond to the diverse and unique needs of women (Addiction Research Foundation, 1996).

Kearney (1997) states that women-centred approaches succeed where past methods fail because they remove the barriers to accessing treatment. These approaches treat women within the context of their lives, which means, for example, that considerations such as day care, transportation and safety in a same-sex environment are built into the program design. Concepts such as flexibility, providing a range of treatment approaches and options, incorporating a relational model of treatment where women's relationships with others are seen as strengths as opposed to problems, and ensuring there are clear strategies for empowering women as opposed to further pathologizing them, characterize the writing about programs that are adopting a women-centred approach:

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[1] Although it is beyond the scope of this report, it is important to recognize that these principles apply similarly to First Nations women and to other marginalized women whose life context differs from the mainstream.

[2] Specifically, they identify the cognitive-behavioural, bio-psychosocial and harm-reduction approaches, suggesting that respectively they offer ways to understand the woman's thinking processes about herself and the addiction in her life – a viewpoint that sees her within the context of the larger society and provides methods to help her reduce the risk associated with substance use.

> Effective care stresses harm reduction – helping women to reduce their stress, stabilize their living situations, get good nutrition during pregnancy, access general health care for themselves and prenatal care, reduce (if they can't stop) their use of alcohol and other drugs, reduce or stop use of alcohol/other drugs at any time possible during pregnancy (Poole, 1997).

Women-centred care along with a complementary continuum of services was advocated as a framework for addressing women's substance use in a report to the Minister of Health of British Columbia. This framework contained the following elements:

- gender differences are recognized and directly addressed;
- women are encouraged to be active participants and knowledgeable about their care;
- collaborative practice is the model for the work undertaken by women and their health care providers;
- the diversity of women's needs over her life cycle and among populations are responded to;
- the service delivery environment is accessible and welcoming, regardless of literacy or child care needs, and has flexible hours;
- wholistic and comprehensive approaches that incorporate different knowledges, disciplines and traditions are employed; and
- popular education and consciousness-raising, community development and organizing to bring about positive changes in the health of both men and women are emphasized (Poole, 1997, p. 7).

Several reports aim to assist service providers and policy-makers in developing preventive approaches for substance-using Aboriginal women (Aboriginal Nurses Association of Canada (ANAC), 1996; George, 1995). The description of effective care in these reports corresponds closely to the elements of the approach outlined above. However, they also stress the importance of approaching the roots of problems from a proactive community-wide perspective as opposed to addressing it as an individual woman's problem. Early education of young women and, later, women and their partners of the potential effects of using substances during pregnancy, along with specific strategies aimed at increasing women's self-respect, are identified as key for long-term prevention. The significance of cultural reconnection (connecting women to traditional Aboriginal values and beliefs; e.g., recalling women's valued place in traditional Aboriginal culture) is featured, as caring for each member of the community has been key in traditional Aboriginal cultures (ANAC, 1996). The process of reconnecting Aboriginal women to their traditional ways and community may indeed provide insight for the non-Aboriginal community, as finding hope for the future is often connected to a sense of belonging and being cared for.

The importance of a power analysis is increasingly being recognized as benefiting practitioners in treatment programs, as well as women themselves. Programs that do not recognize that treatment programs or other types of therapeutic sites are "often sites of the exercise of power in modern societies, which normalize individuals and adjust them to the demands of the dominant oppressive institutions" (Young, 1994, p. 48), may in fact serve to replicate many of the practices that created the struggles for and within women that their substance use reflects. Unlike Kearney (1997), Young (1994) advocates adopting a concept of empowerment that encourages the development "of a sense of collective influence over the social conditions of one's life" (p. 48), as opposed to one that focuses simply on personal transformation.

As well as the importance of power in understanding and responding to women whose substance use is problematic, the awareness of an entrenched, historic "double standard" for women has emerged through the literature on women and their addictions. In this regard Clemmons (1985) says that "capacity to bear children has always set her apart, and with that privilege has come the burden of living with an imposed double standard" (p. 75). Clemmons found that childbearing capacity historically created an attitude that women needed to be protected and encouraged the idea that there is a strong connection between immorality, sexual promiscuity and women's alcoholism:

> As is frequently the case, concern about women is focused on what she does rather than who she is. The concern is for her effect on society in a moral arena or a maternal arena; it is not the woman as person who is valued but rather the role she is fulfilling for society (Clemmons, 1985, p. 78).

Other authors have also identified how this double standard has arisen, highlighting access to Employee Assistance Programs (Miller, 1982), reduced funding that is available for research on women (Rhodes and Johnson, 1994), heightened stigma for women with regard to addictions, which contributes to women's difficulty in accessing treatment programs (Turnbull, 1989), and the sense that women are doubly deviant relative to men with similar problems (Kagle, 1987).

Substance Use During Pregnancy

Since the mid-1980s, substance use during pregnancy has been viewed as a significant social problem, prompting increased efforts to identify mothers who behave in this manner (Gomez, 1997; Ostermann, 1995; Beckett, 1996). In the *Public Policy Statement on Chemically Dependent Women and Pregnancy* (American Society of Addiction Medicine, 1989) substance use in pregnancy is described as causing "adverse affects on fetal development," thus identifying this group of women as "extremely important candidates for intervention and treatment" (Tanner, 1996, p. 125). A range of theories about the nature of addiction have guided the development of resources and helping approaches to women. Furthermore, these approaches are embedded in the prevailing attitudes in society about women, drugs, alcohol, pregnancy and mothering. Professionals have claimed that women are both motivated to change behaviours that may harm their fetus and are open to the assistance of professionals during the pre- and early post-natal period (Bruce and Williams, 1994; Tanner, 1995; Albersheim, 1994). "In national surveys, women report pregnancy as a key reason for stopping use" (Poole, 1997). A mother's attachment to becoming a mother and desire to care well for her infant has provided the basis for what has been seen by professionals as "a window of opportunity" for professional intervention (Bruce and Williams, 1994; Finklestein, 1994).

In the past 10 years there has been a sharp increase in the number of infants born with birth abnormalities traceable to substance use by the mother during pregnancy (Schroedel and Peretz, 1994). However, the extent of the problem is difficult to determine accurately. Screening for alcohol and drug use during pregnancy is not consistently done and women tend to under-report their use for a number of reasons, including shame, fear of losing their children, lack of understanding of the effects of use on the health of the growing fetus, denial of the problem by women and those close to them, lack of child care and lack of accessible treatment. It is estimated that between six percent and 20 percent of all pregnant women use drugs or alcohol while pregnant (Albersheim, 1992; *Motherisk*, 1996). In a study that looked at prevalence of substance use among Aboriginal single women, pregnant women and unemployed men, 41 out of 54 Friendship Centre respondents reported use problems, primarily with alcohol, among pregnant women[3] (Scott, 1992).

Screening methods that have been used primarily in hospitals and health settings have been criticized for an inherent class and race bias in their design and application (Noble, 1997). Critics are now questioning the accuracy of the original research that gave rise to the "moral panic" (Gomez, 1997; McCormack, 1998; Beckett, 1995). Questions are also being asked about why certain substances and certain lifestyle factors are singled out for attention, while others (such as poor nutrition because of poverty) that are known to also pose harm to the fetus are not.

"Fetal Alcohol Syndrome is the only alcohol/drug related birth defect with specific diagnostic criteria...the impact of use of solvents has not been documented" (Poole, 1997). The widely held presumption that has equated all substance use to harm for the developing fetus is beginning to be critically re-examined. Concerns have been raised that serious public policy decisions are being made without up-to-date and accurate science, and that policy unknowingly is based on research findings that have significant flaws (McCormack, 1998; Daniels, 1997; Beckett, 1995). Problems such as small sample sizes, over-representation of minority women, and study designs that did not separate out variables with potential effects contribute to the difficulties encountered in generalizing the results of much of the research in this area (Gustavsson and MacEachron, 1997). Exaggerated claims of harm due to poor methodology are not the only problems that have been noted. A study that analysed bias within predominant medical journals toward accepting or not accepting articles on this topic found that articles that showed a negative effect on the fetus from cocaine use were five times more likely to be published than articles that found no effect at all (Koren et al., 1989). Daniels (1997) also reported that even when studies were published that refuted exaggerated claims, they were not reported in the national media.

Increasingly, substance use during pregnancy has been equated with child abuse, and many mothers have lost custody after birth once their substance use is confirmed. Through the interplay of powerful discourses, mothers-to-be are transformed into "pregnant addicts" who are considered at best sick and at worst criminal. They are identified as "those bad mothers" who do not adhere to the predominant ideologies of motherhood, and as such are caught up in discursive practices that seek to "treat" or "punish" them. Swift (1995) argues that social intervention is made legitimate through that creation of categories (of scapegoats) that imply deviance from the socially accepted standards. "Parenting is a care of a specially administered kind determined in relations outside the mother's experience but imposed upon her (and all mothers) as a standard to aim for" (Swift, 1995, p. 118). Standards have also been socially constructed regarding prenatal care for the fetus throughout its gestational course to maturity.

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[3] This study was undertaken by the National Association of Friendship Centres Urban Research Project: Alcohol and Solvent Abuse, 1985.

Several trends have coincided with the construction of this dichotomy, beginning with the discovery in the 1970s of the diagnosis of Fetal Alcohol Syndrome (Clemmons, 1995). This diagnosis was viewed both as devastating to children and preventable if women's substance use could be curtailed or controlled in some manner. It also enabled the fetus to be viewed as separate from the mother and in need of protection from her "immoral" or "irresponsible" behaviour. A new understanding of the vulnerability of the fetus to its mother's lifestyle choices emerged. Technological advances also began to shape a different social understanding of the fetus as a person, separate and distinct from its mother, and a patient in its own right. Ultrasound technologists also began to intervene psycho-socially with mothers, introducing them to the baby and encouraging bonding with those women they judged to be inappropriate in their initial presentations as a mother (Mitchell and Georges, 1997). The fetus as patient began to be conceptualized in the health discourse as an entity with its own interests, and for some, its own rights.

Along with the transformational impact of technological interventions that promoted the sense of the fetus as a separate individual from its mother, other events in the United States have encouraged the polarization between substance-using mothers and their babies. The renewal of the abortion debate in the United States along with the "war on drugs" enabled pregnant addicts to become the "poster women" for these causes, justifying the rhetoric of the dominant interest groups and illustrating their version of what was wrong with the family in America today. Although efforts to overturn the landmark Roe v. Wade decision failed, the war on drugs had become by the 1980s "a war on drug users" (Gomez, 1997, p. 2). It was far more than a public relations exercise for the conservative politics of the day, as its rhetoric demanded punishment for those (drug users) who were the targeted enemy in this war. Its discourse served to legitimize spending increases in the area of law enforcement; between 1970 and 1992 in the United States public spending for drug interdiction rose from $200 million to $13 billion. During this period, law enforcement agents doubled the conviction rate for drug offenders – primarily drug users – who were then portrayed in the media as "the black and brown underclass" (ibid.).

The dichotomous thinking that is reflected in the concepts of "good" and "bad" mothers is also replicated in the charged "fetus' versus mother's" rights debates. This has led to serious consequences for women in the United States, where Whiteford and Vitucci (1997) suggest that "the war on drugs has turned into a war on women" (p. 1371). A polarization in the discourse has resulted, pitting mother against child, as the debate continues around whose rights should be paramount (Boscoe, 1997; Miller, 1997; Young, 1996; Center for Reproductive Law and Policy, 1996).

The double standard faced by women is readily apparent in a report by Schroedel and Peretz (1994) that claims that in 1989, 1990 and 1991, the *New York Times* printed 34 articles dealing with "fetal abuse," linking it directly to the mother's "lifestyle choices." There was no mention, for example, of how men's lifestyle choices may adversely impact fetal outcomes. Daniels (1997) further challenges the mother-blaming focus of much of the rhetoric in this area by raising the question of the impact of affected sperm (through legal and illicit drugs or environmental toxins) on the health of the developing fetus.

> The exclusion of men from studies on the influence of drugs on the fetus lends credence to the notion that research serves the purposes of the power elites who want to police women and control their behaviour (Gustavsson and MacEachron, 1997, p. 676).

Moreover, although substance use in pregnancy has been constructed as child abuse through media coverage of the issue and policy initiatives aimed at prosecuting mothers, there has also not been a parallel discourse of the situation of woman assault during pregnancy and the potential that is inherent for damaging the fetus (Schroedel and Peretz, 1994).

Debates on Punishing Women and Protecting Children

Law and policy in the area of substance use during pregnancy have typically been framed in two ways: as a means to punish "abusive" mothers or as a means to do something for "high risk" infants. Johnsen (1992) describes this as the outcome of the adversarial model that sees the pregnant woman as two distinct entities – woman and fetus – "each with separate and conflicting interests" (p. 576).

Prosecution of women for their behaviour during pregnancy has targeted women of colour and lower socio-economic class, and in "Florida, South Carolina and in several other states, pregnant women can also be jailed, purportedly to 'protect the fetus from damage', if the mother has acknowledged drug use" (Whiteford and Vitucci, p. 1372). Their research has suggested that punitive laws such as these are less about protecting the unborn and are more about punishing women for being poor, pregnant and addicted.

Those who are against punitive approaches, such as criminal prosecution or coercion via the child welfare system, argue that threatening mothers results in poorer maternal and fetal health because women go underground to protect themselves and their infants from the system and, while doing so, avoid beneficial prenatal care (Center for Reproductive Law and Policy, 1996). "A pregnant woman with a drug problem understands that the threat of arrest or loss of custody originates from those to whom she might turn to for help" (Noble, p. 188). Protagonists against punishment policies claim that addicted pregnant women are less likely to receive addiction treatment services as a result of this, and that in effect this approach causes more harm than it prevents. Other concerns are raised regarding women's human rights, particularly in the areas of privacy, due process and racial justice (Center for Reproductive Law and Policy, 1996; Johnson, 1992).

Suggestions for legislative and policy changes to support women and encourage healthier women and infants were developed by the Coalition on Alcohol and Drug Dependent Women and their Children. These include:

- provisions to ensure pregnant substance-using women be protected from incarceration for any reasons relating to the (potential) impact of the substances on the fetus;

- provision that positive drug screens can be used only for medical purposes, not as the sole grounds for removing a child;
- provision that substance use alone, without additional evidence of the inability to safely parent, does not constitute a requirement to report to child protection services;
- provision for comprehensive treatment programs for women that cannot exclude pregnant women; and
- provision for a review of agency services with the goal of improving the coordination of services among all related programs (Center for Reproductive Law and Policy, 1996).

According to the Center for Reproductive Law and Policy, some U.S. states (i.e., Iowa and Kansas) have passed legislation prohibiting discrimination against substance-using pregnant women.

Policy and Policy Making

What do we mean by "social policy"? Social policy can be viewed as political activity by the state in which values are expressed, resources allocated and quality of life issues addressed (Prince, 1992). While writing about the connection of policy to practice in human services, Wharf and MacKenzie (1998), describe the process of making social policy as:

> ...choosing directions in situations in which choices are clouded by conflicting values and where facts and information cannot be marshalled to establish clearly that one choice is superior to all others. Thus the term "policy–making" is reserved here for wrestling with and deciding among various difficult choices (p. 10).

Some policies are developed purposefully to target a specific issue (e.g., pregnant substance-using women); others are designed for other purposes but affect the issue (e.g., population health initiatives). These policies, along with underlying prevailing attitudes and ideologies of our society, combine to shape professional practice and, consequently, the everyday experience of women in circumstances like those of Ms. G.

Policies take numerous forms. Some address "grand" policy issues that pertain to the fundamental structure of political-economic life; others address "ordinary" policy issues that affect the daily lives of women and those who are trying to assist them in significant ways (Wharf, 1992). Some are adopted formally, others become part of the informal ways things are done. Ideally, "policy is a principle, plan or course of action that is continually responsive to changing needs and environments. It is a 'living' experience" (Prince George FAS Community Collaborative Network, 1998, p. 29).

One question to consider when examining social policies is how well the particular policy connects or links with others, both regarding similar issues and from different policy-making levels or locations.

> Since most social policies are conceived of at the national or provincial levels but implemented in local communities, are the present linkages and connections

> sufficient to ensure that social policies meet the needs of local communities? (Wharf, 1992, p. 12)

Other questions relate to the policy-making process. How, where and with whom policy is developed may affect its relevance and its ability to be successfully implemented. Although "top-down" or power-based models of policy making are more traditional and familiar to most, the problem to be addressed is often first identified in local settings. The recognition of this, along with the understanding of policy making as "a dynamic process of interaction and development" (Prince George FAS Community Collaborative Network, p. 29) has encouraged alternative, more participatory models to be developed.

Those who have traditionally had the most power within policy making resemble the familiar cast of most power elites in Canada – predominantly white, middle-class males from professional or business backgrounds (Wharf and MacKenzie, 1998, p. 19):

> Relatively few women, poor people, and members of ethnic minorities took part in the decisions that affected them. Although the membership of women has increased, significant participation by other groups is absent from local governing structures (ibid.).

Including "the wisdom of practitioners and those affected by the policy-making process," those who have not traditionally sat at the table is one way these authors suggest to "improve the human condition" that current methods have failed to do (ibid., p. 3).

Titmuss (1974) suggests that policy making occurs at different levels. He identifies these as government, community and individual, and suggests that action or non-action in each influences directions that are ultimately chosen. In this chapter, we will look primarily at policy choices at the level of governments, as that is the location where the Supreme Court suggested that policy decisions related to this issue should originate.

Wharf and MacKenzie (1998) stress the strong link between ideology[4] and politics, suggesting that government decision making does not occur solely as a rational, orderly process, but is complicated by partisan politics and strongly held beliefs and ideology (p. 11). The prevailing ideologies and values that influence decision making in government set directions in legislative reform, policy development and generate significant consequences for resource allocation. This intimate connection between ideologies and politics – and politics and policy decision making – is underscored in the chapter of this report that analyses the Supreme Court decision and the media coverage of the case, and in the chapter that presents women's, workers' and Aboriginal people's views on how current policies affect their lives.

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[4] Their example focuses on the ideology linked to social philosophies such as Marxism, liberalism, etc. I would also expand this to consider ideologies that guide decisions on policies related to women, Aboriginal peoples, addiction and mothers – ideologies that are highly significant to this issue.

Finally, although social programs are funded through federal-provincial cost sharing arrangements in Canada, the federal government sets policy directions and funding priorities that are developed to create the preferred direction for the provinces and other stakeholders to follow. These shape the context in which the problem is addressed. Initiatives developed in line with these priorities can provide a significant source of additional funds that can be used to augment those monies already earmarked at a provincial level for health care and education. In the situation of women using substances during pregnancy, the directions set by federal policy may steer local agencies toward either punitive or support-driven measures.

Policy Context – National

To understand how Canadian policy addresses substance use during pregnancy, the ways that the federal government directly influences and/or institutionalizes[5] policy in this area were examined. Although influenced by our neighbours to the south, Canada has prided itself in and perhaps defined itself by its different public policy directions, so clearly illustrated by the Canadian health care system. Despite this, our attitudes and understanding of the nature of the problem are influenced by the full range of similar discourses – from scientific and medical experts to the media and claims of legislators and politicians.

Although no evidence of a national stand-alone policy designed to specifically address pregnancy and substance use was found, there are myriad policy decisions in a number of government areas that directly and indirectly relate to this issue. Some of these are described in the following section.

Canada's Aboriginal Policy

Although it can be argued that any policy or program that does not take the root causes of serious addictions into account will simply result in band-aid solutions rather than true healing, nowhere is this more apparent than when considering the experience of Aboriginal[6] women like Ms. G.

The relationship of the state to Aboriginal peoples is defined in Canada by the *Indian Act*, which itself reflects the continuing ideological position of successive Canadian governments. Historically, Aboriginal policies have been created with the specific intent to protect, civilize and assimilate Aboriginal peoples within the Canadian mainstream (Sterling-Collins, 1991). The horrific impact of this legacy is found in the over-representation of Aboriginal people in our courts, social services and child protection systems. This is described more fully in the chapters that follow in which Aboriginal women recount their struggles within the context of current issues and historical oppression.

Relationships between Aboriginal nations and the Canadian state, however, are currently evolving as treaties and agreements that move Aboriginal peoples toward self-government are negotiated. Aboriginal women, in the interim, continue to be oppressed in multiple ways as they are affected by the racism inherent in current Canadian policies and, like other women who use substances while pregnant, are subject to the stigma that occurs when their problems become publicly known.

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[5] Institutionalization refers to how the problem becomes addressed in a standard or routine way, usually by special personnel who are allocated resources to measure, count or solve it (see Gomez, p. 7).

[6] The term "Aboriginal" refers here to three groups of peoples: Canada's First Nations (who include individuals defined as "status" and "non-status" under the *Indian Act*), the Inuit and the Metis.

The Medical Services Branch (MSB) of Health Canada delivers community health services through contribution agreements with communities to those people who are designated as registered status Indians and Inuit peoples south of the 60th parallel. Agreements are program-specific (e.g., Brighter Futures and the National Native Alcohol and Drug Abuse Program or NNADAP) and the community employs the staff to run them. Programs have been designed by MSB with little variation in the services delivered from community to community. There is no local input into the planning and design of the program, but the service can be delivered in a manner that fits a particular community's needs. Changes in this funding arrangement would enable communities to set their own priorities through a community health management system and a block funding agreement. In addition, specific services are earmarked for eligibility. These include solvent use treatment, NNADAP Prevention Services and Brighter Futures, which are all initiatives that directly serve Aboriginal women who use substances while pregnant.

An exception to the registered status requirement is the more recent approach adopted by the Health Promotion Branch with the implementation of its Head Start Initiatives. These programs include all Aboriginal children, not simply those designated as "status." For women living on-reserves, health programs are federally designed; women who live off-reserves have access to whatever local or provincially designed programs exist in their area. Federal and provincial jurisdictional issues have been debated for years and continue to present a challenge to the development of effective prevention programs:

> The distinction between Status and non-Status, on-reserve and off-reserve, populations appears to lie at the heart of this debate. The result is that many essential programs and services for Aboriginal people are simply not provided. It is essential that the province works collaboratively with the federal government to resolve these issues (George, 1993, p. 47).

It is also critical to recognize that, as in mainstream society, there is not one consensus or Aboriginal approach that is currently agreed upon as the way to address the issue of substance use in pregnancy.

Drug Policy

Recent events in the development of new drug legislation in Canada are useful to consider, as the principles expressed in the final legislation support or hinder future efforts to assist pregnant substance-using women. Throughout most of the twentieth century, Canada's strategy on drugs focused on prohibition and enforcement, thus thrusting the policy focus (and major resources) toward individual drug users. Canada's Drug Strategy (CDS) was announced in 1987 as an initiative aimed to shift the prohibition approach to one that emphasized the principles of harm reduction.[7]

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[7] Harm reduction is closely linked to health promotion and healthy communities models that have recently developed in the field of public health. Conceptually, harm reduction adopts a value-neutral approach toward drug use and drug users. They are not

A new law to form the legal backbone for the new framework was originally included in the proposed policy overhaul (Fischer, 1997). The proposed legislation, known as Bill C-85, died following the Liberal government's return to power. Critics were relieved as this Bill was seen as flawed and not true to the public health principles espoused in CDS. The Liberal's replacement legislation, Bill C-7, was also criticized despite the Liberal claim that "this is not a policy Bill so it should not be confused with drug policy" (Fry in *Hansard*, 1995). The Liberals argued that law enforcement and social policy are separate and can have different agendas, despite the original intent and purpose for the Bill as it was conceived within the CDS. Critics argued that Bill C-7 was a carbon copy of the previous Bill. It continued to concentrate on drug control and failed to steer legislation into closer harmony with the social and health measures for drug users. Criticism arose from within the Liberal party and from various interested stakeholders. Despite this, and following minor content revisions, it was reintroduced and eventually passed in 1996 as Bill C-8 or the *Controlled Drug Substances Act*.[8]

> While the opportunity to enshrine "harm reduction" principles into the law, and thus to provide a solid legal framework for a more rational "public health"-based public policy has been wasted with C-85, C-7, C-8, the onus for possible progress along these lines will subsequently be shifted to the institutions and programs who work with or around the law in dealing with the issue of drug use (Fischer, 1998, p. 62).

Rather than cementing the new drug policy direction with a harm-reduction philosophy, it appears that a number of competing approaches and directions have been entrenched simultaneously at the federal policy level. Fischer argues that the comments made by politicians at the time clearly illustrate the state of confusion within the new drug law and with the policy development process overall. He offers the statement of Liberal Member of Parliament (M.P.) Reg Alcock (Winnipeg South) in *Hansard* to support his point: "This new law will put Canada in the forefront...of leading the War on Drugs from a perspective of harm reduction" (Fischer, 1998, p. 62).

It is perhaps too soon to completely evaluate the effect of this confusion on related policy making. The implementation experience of the legislative aspect of CDS reflects the close connection between political philosophy, ideology and social policy, and the difficulty that occurs when politics and policy development are so closely allied in an exercise to develop policy initiatives aimed to provide effective federal leadership to addressing a serious social problem.

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seen as sick or deviant, but as normal people engaging in human behaviour. The focus in harm reduction is on the problems caused by use, and the user is seen as integral to developing effective solutions. Programs tend to be user-centred and adopt flexible strategies with goals that are short-term and focused on reducing risk or harm as opposed to a longer-term vision of abstinence (Erikson et al., 1997).

[8] Benedict Fischer provides a detailed description of this recent history in his article "The Battle for a New Canadian Drug Law: a Legal Basis for Harm Reduction or a New Rhetoric for Prohibition? A Chronology." It raises interesting questions about the relationship between legislation and public policy and concludes optimistically, by citing the Australian, Dutch, Swiss, Spanish and German systems, that public-health-oriented policy can arise despite antiquated prohibition laws.

Health Policy

Health Canada is the federal department that oversees Canadian health policy, which in turn is primarily responsible for many of the policy areas that have direct bearing on the population of pregnant women who use substances. An important distinction to make at the outset is that health policy encompasses much more than the provision of health care services to Canadians. It also includes initiatives designed to improve the health status of all citizens, and reflects the responsibilities of both levels of government, federal and provincial, to ensure the requirements set out in Section 36 of the Constitution are met. With the exception of Aboriginal peoples, the provinces have responsibility for service delivery or curative health care. Health policy addresses additional questions outside the direct service delivery realm and these include more preventive public health initiatives that are often referred to as "population health" and "health promotion."

Health Policy – Population Health

The Canadian Council on Substance Abuse (CCSA), in its submission to the House Standing Committee on Health on October 8, 1996,[9] noted that health programming developed under Canada's Drug Strategy was destined to merge with other health and social issues under the label of "population health" (also known as the determinants of health model) due to the sunsetting of CDS in March 1997. The CCSA questioned the priority that this programming would sustain with this merger, but suggested that there were potential benefits to the shift. Unlike the focus on the affected individual that had been prevalent throughout Canada's drug policy, population health allows for the antecedents of the problem to be more wholistically understood and addressed. This approach corresponds more directly with harm-reduction principles, and the CCSA argued that the money saved in corrections and enforcement costs by this shift should be folded directly back in to allow for a stronger continuum of resources for various types of outreach and treatment in health. It is still too soon to evaluate the impacts of this shift, particularly since the provinces, which implement health policy, are still adjusting to cuts in transfer payments that were part of the Liberal's deficit-fighting initiative – a clear reminder of the familiar problem that occurs when rhetoric is not followed by adequate resources.

From October 1996 to June 1997, the Standing Committee on Health conducted a Substance Abuse Policy Review, which at the request of the Minister focused on the demand side rather than the supply side of Canada's drug policy. "However, nothing came of the work of the Committee because a federal election was called in April 1997, before the committee had issued a report. As of mid-1998 there is some discussion about the Senate conducting its own assessment of drug policy" (Canadian Foundation on Drug Policy, 1998). How the findings of this and other potential reviews will be integrated into existing health policy or form the foundation for new policy initiatives remain unclear.

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[9] This committee was struck by the Standing Committee on Health to conduct a "Review of Policies on the Misuse and Abuse of Substances," which included both legal and illicit substances, alcohol and tobacco, and had nine months to conduct its work.

Health Policy – Child and Family Initiatives

Two initiatives of the Community Based Programs Division of Health Canada target substance-using pregnant women and mothers of infants. These are the Community Action Plan for Children (CAP-C) and the Canada Prenatal Program. Both fall under the federal government's Brighter Futures Initiative.

The CAP-C program, which was launched in 1992 as part of Canada's response to the United Nations Convention of the Rights of the Child, enables community groups to deliver services to address the developmental needs of children who are "at risk." Because of the prevalent concern that children exposed to drugs and/or alcohol during pregnancy are at risk for a range of problems, including FAS, Fetal Alcohol Effect (FAE) and Neonatal Abstinence Syndrome (NAS), pregnant substance-using women were included as one of the groups targeted by this initiative. The CAP-C program is jointly managed by the federal government and provincial/territorial governments and, although its overall objectives remain constant nationally, each local jurisdiction has been encouraged to set priorities relevant to its local needs. Currently, CAP-C is funding 392 projects across the country that deliver 1,790 programs. These programs are serving 28,872 children and 27,178 parents and caregivers weekly.[10]

CAP-C also has responsibility for delivering the 1994 federal policy initiative, the Canada Prenatal Nutrition Plan (CPNP), which is another program that specifically targets pregnant women who use drugs or alcohol. The CPNP has contributed to funding for many local pregnancy outreach programs that aim to assist "high risk" pregnant women. These programs have also been designed in different communities to fit local needs and cultures. There are currently 277 CPNP projects under way in Canada.

Although evaluations are currently being completed on both programs, the Brighter Futures Initiative and CDS are the federal policies that currently have most impact on women who are pregnant and using substances. Unlike Canada's Drug Strategy, programs such as CAP-C and CPNP are federally initiated but locally designed. They are based in their communities and therefore respond to local needs, but together form a nationwide network of prevention and early intervention health services for children and their families.

Canada's Criminal Code

The Supreme Court of Canada's 1989 decision that a fetus is not a person until after birth[11] guarantees that prosecution based on prenatal conduct would continue to be unsuccessful in Canada, as the interests of the fetus do not have legal rights or status within Canada's Criminal Code.

Bala and Vogl (1993) state there is no basis in Canada for criminally prosecuting a woman for prenatal conduct that may have endangered her child. However, although unlikely for a series of practical reasons, they note there is the possibility in tort law for a child born alive to launch a civil suit against his/her mother for damages that are directly attributable to her prenatal conduct. In the absence of specific legal sanctions for substance use during pregnancy, the more common approach within Canada, they suggest, has been through attempts to indirectly regulate the mother's prenatal behaviour through criminal prosecutions for other matters, that if or when successful, have allowed the court to impose jail sentences that remove the mother from the environment in which the harm is occurring (Bala and Vogl, 1993). This "protective incarceration" approach has also been the subject of criticism. "The benevolent paternalistic concern of the judge for the health of the fetus might be more commendable if jails provided high quality prenatal care and were, indeed, drug-free environments" (Gustavsson and MacEachron, 1997).

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[10] These figures were taken from the CAP-C national evaluation and were found on the Health Canada web site in the CAP-C online newsletter *CAPC/CPNP What's New*.

[11] The citation for this pivotal case is Tremblay v. Daigle (1989), 62 D.L.R. (4th) 634 (S.C.C.).

Provincial Policy Context

Unlike trends in the recent years in the United States, which have seen a rise in the attempts to criminalize pregnant substance-using women, provincial responses have generally emerged through mental health applications, sentencing provisions (noted earlier), policing priorities, and population-specific, local health-driven initiatives, such as British Columbia's Pregnancy Outreach Programs, or through the use of provincial child protection authorities.[12]

Policies that directly impact women using substances in pregnancy originate both at the local or program level and at the provincial level through particular ministries: health, the Attorney General (corrections), social services (child protection and financial aid services) and alcohol and drug commissions set up as bodies separate from health ministries specifically to address addictions in that province. Delivery systems for services may vary from province to province; e.g., British Columbia has recently adopted a regionalized model of health and child welfare service delivery, which has meant that there may be regional differences in population needs and program emphasis. As policy is generated from multiple levels and locations within a provincial context (e.g., ministries, regions and local program initiatives), an exhaustive inventory of all policies is beyond the scope of this review. A more general "stock-taking" approach was employed and those initiatives that stand out – by their presence (or absence) – will be identified. This report's objective is not to quantify or record every attempt to reach out to substance-using women, but rather take a reading from the nation on where it currently stands from a policy perspective.

Mental Health Acts

Along with prosecuting women criminally on other matters as a means to control substance use during pregnancy, provincial mental health acts have been used as another indirect method of controlling behaviour. In the case of Ms. G., for example, Justice Schulman based his order for detention on two grounds, one being that Ms. G. was suffering from a mental disorder within the meaning of the *Manitoba Health Act*. The Manitoba Court of Appeal overturned the ruling that found Ms. G. to be mentally incompetent under that act. Upon appeal, Justice MacLachlin, in her Supreme Court findings, noted that when orders are made they are usually done to benefit the patient. She did not find this was the main objective of the family court judge in Ms. G.'s case:

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[12] One notable exception, however, is the recent case of Jeanette Reid in Alberta. She was charged, convicted and jailed under the *Alberta Public Health Act* for sniffing solvents while pregnant. Public Health legislation differs from province to province and, to date, Alberta is the only province to apply legislation in this manner. When local child protection and health authorities were interviewed regarding this case, they suggested that this case was a local anomaly rather than a provincial initiative. They reported it had come about due to the efforts of local police authorities who had intervened with Ms. Reid previously with no effect. Their growing concern about the effects of her addiction on the fetus and frustration with lack of success with previous efforts led them to advocate for this approach in this one case.

> While prenatal legal intervention based on concerns about the future well-being of the child is not possible, if a pregnant woman is refusing to consent to necessary medical treatment for herself due to her mental incompetence there may be a basis for intervention. In such cases, provincial mental incompetency law may be invoked to permit some form of "substituted consent" (Winnipeg Child and Family Services [Northwest area]) v. G. (D.F.).

The application of the various provincial mental health acts is limited, as each province's legislation has its own definitions of what constitutes harm and incompetency in order to safeguard the human rights of mentally ill persons. Despite the fact that each province has its own law in this area, safeguards are fundamentally consistent across the country and apply in instances where a mentally ill woman who is also pregnant and using substances comes to the attention of authorities.[13]

Bala and Vogl (1993) suggest that in Canada there is no legal basis for prenatal intervention besides the two possibilities noted above: prosecuting women for an unrelated criminal act and then imposing a sentence that in part addresses the substance-using concern, and substitute decision-makers in cases where there is clearly a situation of mental incompetency that complies with the range of narrow definitions that are characterized within provincial mental health acts. Neither approach is without major legal and ethical problems, and policy critics of these approaches suggest they will only create greater harm and less chance of success as women are driven further underground within punitive policy frames.[14]

Justice MacLachlin, in the Supreme Court of Canada decision on the Ms. G. case, notes that:

> Extending the power of the courts to make this sort of order could have adverse effects; for example expectant mothers fearing state intervention might avoid detection by not seeking desirable prenatal care. The difficulty of enforcement and incompleteness of the remedy presented obstacles. Given the difficulty and complexity entailed in extension of the law the task was more appropriate for the

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[13] Bala, N. and Vogl, R. (1993). *Legal Responses: Abuse and Neglect of the Unborn Child.* Toronto: The Institute for the Prevention of Child Abuse.

[14] There are numerous critics of punishment-driven policies for pregnant substance-using women. For a review of many of the issues, see Katherine Beckett (1995): "Fetal Rights and 'Crack Moms' – Pregnant Women in the War on Drugs," *Contemporary Drug Problems*, 22 Winter, pp. 587-612; Cynthia R. Daniels (1997): "Between Fathers and Fetuses: The Social Castration of Male Reproduction and the Politics of Fetal Harm," *Signs: Journal of Women in Culture and Society*, 22(3), pp. 579-616; and the Center for Reproduction Law and Policy (1996): *Punishing Women for their Behavior During Pregnancy: An Approach that Undermines Women's Health and Children's Interests*. New York: Center for Reproductive Law and Policy.

> legislature than the courts. For these reasons, the Court of Appeal set aside the order for detention (Winnipeg Child and Family Services [Northwest area]) v. G. (D.F.).[15]

Child Protection

Child welfare originated from the desire to protect children from neglect and abuse. In Canada, child protection laws and their implementation fall under the jurisdiction of each province and territory. Services may be delivered by a range of government departments, voluntary agencies and First Nations organizations, depending on the province and location. All, however, are funded by government.

> Although many child welfare systems acknowledge that most of their clients are women and children living on low incomes, not all systems have questioned the theoretical connections between poverty, abuse, gender and "inadequate" parenting (Baker, 1995, p. 238).

Four legal concepts are common to each jurisdiction, underpin and shape the socio-legal relationship of children to the state. Each concept delineates a key aspect of this relationship and must be considered. They are:

- the power of the family (the concept of *patria potesta*);
- the authority of the court to make decisions on behalf of those who are unable to do so (the parent as state, or the concept of *parens patriae*);
- the justification for intervening in neglect cases and used as a standard when making decisions regarding custody and placement (the concept of *the best interests of the child*); and
- that the child has autonomous rights separate from his or her family (the concept of *the child is a person before the law*).

The ideology of "good mother"/"bad mother," along with the historical doctrine of *parens patriae* further legitimates the intervention in the lives of "bad" parents by the state. This is intervention based on the belief that individuals bear the responsibility for their own problems, a belief that does not recognize societal responsibility or that structural conditions may have contributed. "An alternative view of need is that it occurs because of the failure of social forces and the economic system to protect individuals" (Swift, 1995, p. 47).

As substance use during pregnancy becomes increasingly seen as fetal or child abuse, more pressure is placed on communities to screen pregnant women and report those who are determined to be users. Gustavsson and MacEachron (1997) suggest that this policy direction has increased reports to child protection agencies and has resulted in overwhelming workloads for the child protection social workers. "Families are also affected when workloads soar, as resources get directed to completing 'investigations' rather than for providing services to women and their families" (Gustavsson and

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[15] Winnipeg Child and Family Services (Northwest area) v. G. (D.F.). The Supreme court ruling on this case can be found at http://www.droit.umontreal.ca/doc/csc-scc/en/pub/1997/vol3/html/1997scr3_0.

MacEachron, 1997, p. 679). In the first descriptive study undertaken in Canada, Trocme, McPhee and Tam (1995) found that in substantiated child abuse cases, substance use in the form of alcohol or drug use was found in 38 percent and 31 percent of the cases respectively. It was not possible to obtain figures that show the numbers of child protection investigations as a result of reports of substance use during pregnancy. Anecdotal evidence from workers in child protection and hospitals unanimously suggest the incidence of use of child protection intervention is increasing substantially, and that in the majority of child protection cases the substance use of one or both parents is a primary concern." (Callahan et al., 1998).

Besides being ill-resourced to serve families in need, the child protection mandate poses a challenge for dealing effectively with substance-using mothers. Child protection aims to protect children from harm and so it focuses on changing the mother's behaviour to conform with the standard that is set out by the worker. Besides operating within compressed time lines to ensure that decision making occurs at a pace that is child-centred, workers have varying amounts of training and understanding of addictions, and therefore limited ability to assess women's stage of addiction and readiness for change (Callahan et al., 1998; Prochaska et al., 1992). Assessments also do not always distinguish between patterns of use which result in children being neglected or unprotected from abuse, and patterns in which safe arrangements are made when use occurs. The identification of use during pregnancy alone becomes enough "proof" of abuse. Noble (1997) found that child protection workers' actions were based on the results of routine urine toxicology tests, a technology that provides very limited information; i.e., information only about very recent use and nothing about patterns of use (p. 184):

> That such tests are linked to serious interventions has been a matter of concern for policy-making groups (Task Force on Substance Exposed Infants 1990). Such groups have argued against the prescription that if one tests positive for drugs, one is likely to be an abusive or neglectful parent. Others point to the fact that there is no research that demonstrates that the use of drugs during pregnancy is predictive of child abuse or neglect (Larson, 1991, in Noble 1997).

Plans are created by inadequately trained social workers that may be unrealistic for their clients and, as in most provinces child protection services and addiction treatment are provided by different institutions, workers may have unrealistic expectations of the treatment system. Barriers that lead to women having difficulty both acknowledging the extent and effect of their problems and then accessing the best treatment match may be poorly understood as well. Fear of losing custody of children repeatedly arises as one of the primary forces that inhibit women from coming forward for assistance, as the ways that workers tend to ensure women follow "the plan" is through removal or the threat of doing so if she "slips" or uses.

If a women is ready and engages in treatment while also being followed by child protection, ironically, the contradictory focuses of each system in relation to power may pose additional problems for her. As noted earlier, child protection's focus is to help the mother to become a "good" mother. In order to achieve this she must submit and comply with the plan her worker sets in motion. "Slips" or continued use are viewed as posing risks to the child and a sign that she is not able to parent effectively. The focus of the addiction treatment system, on the other hand, is to help her develop and use greater personal power as part of her journey to successful recovery (White, 1998). On one hand, she is expected to submit to outside authority; on the other, she is expected to exercise her autonomous personal power while making choices that are internally driven and linked to a stronger knowledge of self.

In Ms. G.'s case, Winnipeg Family Services attempted to have the *parens patriae* authority extended several ways: to enable decisions to be made on behalf of an addicted mother, who they argued lacked competency to care for herself; and to protect her fetus. This case was also viewed by many, on both sides of the issue, as an attempt or opportunity to extend rights before the law to the fetus.

This case was brought to the courts by child protection authorities who felt they had exhausted available resources and had been unsuccessful in their efforts to assist Ms. G. and her unborn fetus from the solvents she was continuing to inhale. Although this application for mandatory treatment was unusual in Canada, prenatal child protection applications have previously been made in a range of other circumstances in which the mother's actions were thought to be harmful to her unborn fetus. To date, none have been successful.

New Brunswick remains the only province whose child welfare act defines child to include the "unborn." This definition of child has not yet precipitated prenatal intervention by New Brunswick's provincial child protection authorities, and it remains a question if they were to do so, how their actions would stand up to the Supreme Court's ruling that a fetus is not a person (thus with rights) until born.

Bala and Vogl (1993) cite several cases that occurred throughout the 1980s, in which judges equated prenatal drug use with child abuse. In their review of case law on this topic, they found, however, that whether upon appeal or within the original ruling the courts are reluctant to interfere with the liberty and rights of the mother until the child is born. They suggest that England and the United States have followed a similar approach in refusing to make orders to protect the unborn child.

Gomez (1997) notes, however, that in the United States policy development has been polarized between advocates who favour a public health treatment approach and those who wish to adopt a more punitive model.[16] Gomez suggests that child protection falls into the camp of those adopting a punishment approach. Noble's research supports this analysis, calling policies that support practices of drug testing and report positive test results to child protection authorities (who then coerce women into treatment, often removing their children from their custody) "a different form of punishment, one more common than criminal prosecution" (Noble, 1997, p. 174). Gomez found that a higher incidence of low-income women and women of colour were tested and as a group their children were more likely to be placed in foster care (Noble, 1997, p. 182).

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[16] Gomez describes a continuum of punishment approaches that range from harsh or extremely punitive efforts where existing laws are stretched and expanded to address the issue (such as the South Carolina example where Cornelia Whitner was jailed for eight years due to substance use during her pregnancy), to moderately punitive approaches where women are coerced into treatment, and the softer diversion model adopted by New Mexico, which attempts to divert women from the criminal justice system to rehabilitation programs (pp. 81–82). Applying these criteria, the cases launched against Ms. G. and the case of Jeanette Reid, certainly fall under the harshly punitive category.

Although the criminal prosecution model has not been adopted in Canada, prosecutions adapting existing provincial laws nevertheless have been carried forward, as shown in the case of Ms. G. with child welfare and mental health legislation, and more recently through the use of the *Alberta Public Health Act* in the case of Jeannette Reid.[17] Both women were impoverished, pregnant and Aboriginal. Although the state's efforts in Ms. G.'s case were unsuccessful, Jeanette Reid lost her liberty and custody of her child. In Canada, it can be argued, we punish women primarily through our child protection laws, thus creating barriers to effectively addressing the problem.

Addiction Treatment Services

Services for pregnant substance-using women are delivered through a network of government ministries (separate from government), alcohol and drug commissions, funded local voluntary agencies, and self-help networks such as Alcoholics Anonymous, Narcotics Anonymous and Women for Sobriety. There are a variety of approaches to treatment reflected by this web of services: some provide women-centred care, some have programs specific to Aboriginal women,[18] some include families, and some have a range of options or ways to be helped. As women and workers tell us in the following section, accessing responsive care in a timely fashion is not easily achieved in most instances. As well, internal policies, such as length of time a client is "clean" before being eligible for admission, still pose barriers to ensuring pregnant women receive the help they request when they are ready. Moreover, these policies, in effect, work against efforts to priorize pregnant substance-using women on waiting lists.

With a superficial glance at the lists of services each province offers for addictions, one might assume that women are blessed with numerous program options.[19] It is important to recognize, however, that of the programs listed, few may indeed be women-centred, and fewer still are set up specifically to reach out to pregnant substance-using women. As Chapter 4 will show, finding services that respond effectively when help is requested is still a challenge for many women. This is illustrated clearly in Poole's (1997) report, which shows a disproportionate need between program spaces and demand for service in British Columbia. For example, of the 10 residential programs funded by the province at the time addiction treatment services was transferred to the Ministry for Children and Families, only three had women-specific services. This is despite the fact it is estimated that between 700 and 1,000 clients in British Columbia seek this type of service annually. In 17 detox facilities across the province, there were no detox programs for women (p. 16).

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[17] At the time of writing this is the only case in Canada in which the *Public Health Act* has been used to stop a pregnant woman from using substances.

[18] The National Native Alcohol and Drug Abuse Program, a division of Health Canada's Medical Services Branch, offers programs in some communities to Aboriginal "on-reserve" clients.

[19] In 1995, for example, British Columbia funded 191 programs ranging from detox facilities to residential treatment programs (Poole, 1997).

Although this example shows only the situation in British Columbia, other provinces would have to be assessed in the same way before one was certain that they had an accurate understanding of the current state of treatment opportunities for women in Canada. Certainly, Poole (1997) notes that among the major challenges to implementing "a comprehensive, integrated" model in British Columbia has been the "lack of services for those needing immediate residential care such as pregnant women with substance use problems at risk of having a child affected by alcohol and drug related effects" (p. 18). As Gustavsson and MacEachron (1997) note, "it misses the point to ask a pregnant user to wait six months for a drug rehabilitation program" (p. 681). To date, few provincial systems have substance-use treatment or prevention programs specific to Aboriginal cultural needs (Scott, 1992). Recent initiatives such as Manitoba's STOP FAS partnership with the Aboriginal Health and Wellness Centre and the Nor'West Co-op Community Health Centre are attempting to redress this using a model that will attempt to reach out and support pregnant substance-using women for up to three years (Manitoba Government, 1998).

Provincial Initiatives

Other provinces are also developing initiatives aimed at prevention. British Columbia, for example, is directing funds through its Building Blocks Program (sponsored by the Ministry for Children and Families). Each region has developed a plan (by a process of their design) to reach out to high-risk pregnant women and children in their communities via this initiative, and assisted by *The Community Action Guide: Working Together for the Prevention of Fetal Alcohol Syndrome* (released in November 1998). How these plans will develop and be realized is not yet known, but they hold promise given their predominantly public health focus and local design.

The Prairie Province FAS Initiative was launched in spring 1998 and is based on a partnership model where provincially based projects will be shared among the provinces of Alberta, Saskatchewan and Manitoba. As part of this initiative, all provinces have agreed to:

- study the idea of priority placement for pregnant women in addiction treatment facilities;
- extend Saskatchewan's program of community grant initiatives, which enables local communities to receive funding for locally developed awareness and education campaigns;
- launch broad media/public awareness campaigns about FAS prevention; and
- rotate the host duties for an annual interprovincial symposium that is aimed at continuing education and opportunities for joint planning.

The Web sites for each province were searched for initiatives in the past two years that are directly targeted to this group of women. With the exception of the provinces mentioned above, no other new initiatives were found. All provinces, however, provided some form of pregnancy outreach program aimed at improving the health of socially high-risk women and their infants. Although these are important programs, the need for a strong, comprehensive network of treatment services remains. There was little evidence throughout the country that additional funding is being provided.

Several key thoughts emerge from the literature. A woman's addiction to substances pre-exists her pregnancy. Women do not start using drugs when they learn they are pregnant. As Noble (1997) observes, "Drug use during pregnancy is not exemplary behaviour and the impetus for concern is understandable" (p. 174). Women who use substances for the most part agree that they do not want to harm their babies (Callahan et al., 1998; Rosenbaum, 1981).

The search for understanding women's experience of addiction is now more prominent in the literature as understanding grows about how these problems develop and which treatment approaches particularly suit women. Traditional approaches that are based on shame and confrontation replicate many of the life experiences that gave rise to women's struggles initially, thus perpetuating their pain rather than easing it. Women of Aboriginal origin have additional needs related to history, power and culture that need to be addressed.

The literature does not demonstrate that punitive policies are effective. On the contrary, many authors expressed concern that punitive directions lead to poorer health outcomes for women and their children. Tension exists between the aims of the child protection and addiction treatment systems, and this is reflected throughout the experience of the women who were interviewed during this project.

The snapshot of policy in Canada presented here illustrates the enormity of the challenge to ensure that policy directions are linked across the various levels and locations that decision making occurs. We are learning that the process of decision making, as well as who is included in the process, is key to the relevance and responsiveness of the policies that are developed. Within the literature we found a disproportionate volume of material that was about substance-using women; however, we heard far too little that was directly from them.

CHAPTER 2: AN ANALYSIS OF THE SUPREME COURT DECISION IN THE CASE BETWEEN WINNIPEG CHILD AND FAMILY SERVICES AND MS. G.

By Marilyn Callahan

Introduction

This chapter examines how substance use by pregnant women has been framed as a policy concern, as evidenced by the Supreme Court judgment in the case of Ms. G. and Winnipeg Child and Family Services (Northwest Area). This case was selected for analysis because it was widely discussed in the media and is now in referred to emerging academic and professional literature (McCormack, 1998; Poole, 1998). Without a doubt, the court decisions and the media attention before and after the decisions contributed significantly to current Canadian perceptions of the importance of and solutions for the problem of pregnant women who use substances.

Research Methods

The research methods used to analyse the judgment and related documents consist of a thematic analysis, informed by some insights from critical discourse analysis. I focused my inquiry on the Supreme Court judgment and the factums submitted by the Appellant and Respondent. Although some of the interveners' statements were reviewed, they were not included in the detailed analysis because of the sheer volume of the material in the judgment and arguments.

I began by reading the arguments and judgment several times, and recorded what themes and issues struck me as important. In collaboration with Deborah Rutman, the researcher examining the media coverage of the judgment, we developed questions to help us examine the text. These questions relate to the overall research question: How has substance use by pregnant women been framed as a policy issue?

1. a) What is identified as "the problem(s) and solutions?"

   b) What are the processes and techniques used to identify the problem and solutions?

2. If not included in the above discussion, what if anything is said about:
   - addictions and their impact on fetal development;
   - Aboriginal issues;
   - women and mothers; and
   - Ms. G. herself.

3. If not included in the above discussion, who has the opportunity to talk or claim authority and who does not?

4. What is left out?

I then developed a summary of the arguments of the Appellant and Respondent and compared them to determine the overall structures of the argument. I analysed their structures because they greatly influenced the opinions of the Majority and Minority reports and were accepted almost in their entirety.

I returned to the texts to identify patterns of language and how these are used to support arguments and shape meaning, using some techniques of critical discourse analysis. I had to limit further examination, which would have led to a very lengthy process and volumes of written material.

Critical discourse analysis is founded on the belief that language is not neutral and that "many of society's inequalities and injustices are enacted, reproduced and legitimated by text and talk" (Huber, 1998, p. 39). Critical discourse analysis does not provide one coherent approach to deconstruct "text and talk," but challenges researchers to use linguistics, semiotics, cultural studies, feminist analysis and other approaches. The focus is on understanding how the structure of language and the construction of text reaffirms power inequities. Both quantitative and qualitative methods are used in discourse analysis. Researchers spell out the process they use to analyse the discourse, including the lenses through which they themselves interpret "the talk."

Van Dijk (1988) provides some particular tools for critical discourse analysis. He suggests that there are at least four conventions that are used in text that influence meaning. One, *macrostructural* analysis, suggests that readers tend to derive meaning from texts according to the knowledge they already possess about the world (Van Dijk, 1988, pp. 13–14). Members of a culture generally share knowledge about certain events – for example, about what it means to "go for a drive" or to "graduate from high school" – and therefore often draw on similar information in the interpretation of texts.

Another convention, *relevance structuring*, refers to the simple principle that the most important information in a text is often stated first. Whole texts and even sentences can be examined in terms of relevance structuring.

Intertextual analysis takes this insight one step further and examines the relationship among central messages. For instance, readers' views of a passage or text are influenced by what comes first and they may read the passage in terms of the stage that has been set by the writer from the beginning. Newspaper writers greatly influence the reading of a story by the headline, captions and first paragraph. Following the same logic, readers are often influenced by previous texts on the same subject. Thus the first story about women and alcohol use during pregnancy can influence the interpretation of subsequent stories.

The third convention, *grammatical* analysis, investigates how meaning is invoked and reproduced at the level of the sentence. One particular grammatical approach – the application of active or passive voice – is particularly revealing in determining how authority for an idea can be subtlety invoked.

Finally, *rhetorical structures* refers to a variety of strategies employed to make the text more persuasive. Techniques such as repetition, rhyme or assonance, hyperbole or understatement, and sharply contrasting images, words and sentences, build a climax. The use of some of these techniques and their impact are noted throughout the presentation and analysis of the data. Where possible, I quote the original text so that readers can make their own assessments.

As a researcher, my own values and opinions on the issue obviously influence how I read and interpret text. I was relieved in part by the Supreme Court decision and was impressed by the arguments of the Majority report. At the same time, I felt disquiet because the issue had portrayed "women's rights" in such an unfavourable light and had pitted these rights against those of the fetus. I also felt that, although mandatory treatment was not the answer, we should not ignore the harm that may occur to women and children when substances are used during pregnancy. I also believe that no woman wishes harm to her fetus and will take actions to prevent harm if opportunities exist.

Legal arguments are used frequently to transform individual problems and issues into public debates, and are often featured in the media. This chapter examines how this particular legal judgment was covered in the media, using a similar research approach. Altogether, the judgment and its media coverage has done a great deal to influence public perceptions of the issue of substance-using pregnant women.

The Legal Argument as a Process for Constructing Problems and Solutions

The data provide evidence that the legal arguments made by the Appellant and Respondent and contained in the Majority and Minority reports of the Supreme Court are limited in providing an understanding of the issues involved in pregnant women and substance use and possible solutions. The reasons for this finding is at once obvious and complicated. From the outset, legal arguments must find points of law around which they are structured. Information not pertaining to those points of law is omitted. The points of law selected for mounting an argument may not pertain most directly to a full understanding of the problem at hand but to their potential "winnability." The issues not discussed naturally assume less importance. In this particular case, one major point of law – whether the fetus should be granted legal rights or not – occupied a central place in both arguments; other points not directly related to this central issue were simply not raised. What is not discussed, however, may have great importance in understanding the issue of substance use and pregnancy. For instance, the nature of addictions, the causal factors and the impact of gender, race and class on the experience of addicts were simply not raised.

Legal arguments provide the illusion that all important matters have been aired through the process of debate, when it is assumed that each side will exhaustively plumb the issue to mount all arguments in its favour. This did not occur in this case for the reason mentioned above: some aspects of the issue did not pertain to the legal argument selected as most likely to win the case. Moreover, one side may not refute the arguments of the other because it has selected another point of law as the focus of its presentation. Thus, the arguments of either side may be left unchallenged yet remain on the record. This occurred in several places in the factum arguments and court decision. For instance, as the Respondent intended to focus solely on the matter of fetal rights, it had little interest in disputing claims about the impact of mothers' substance use on the fetus. All of these assertions introduced by the Appellant were left unchallenged, even though the matter is complex and far from clear, even to experts.

In many ways, rather than provoking debate, legal arguments can pass like aircraft at different altitudes, each intent on its own destination without much concern for the other, as was apparent in this case. The Appellant was intent on convincing the court that present law could be stretched to cover this particular and extenuating situation, and thus spent much time talking about the precedence for doing so. On the other hand, the Respondent was intent on lifting this situation from the particular to the general and connecting it to other contentious issues such as abortion, demonstrating what havoc would be created if the court allowed the argument of the Appellant. One mounted a particular argument about this particular women; the other, an argument focused on the general issue and the limits of the law.

The notion of debate also obscures the fact that each side may share many common beliefs. These unspoken and uncontested beliefs gain subtle credibility because they are not brought to light and are not challenged. For instance, the notion of independent and equal Canadian women who freely choose their lifestyle was left unexamined by both Respondent and Appellant.

In the end, the Supreme Court, Majority opinion, referred the matter of fetal rights to law-makers for their consideration. The limited understanding emerging from this legal debate will undoubtedly influence the subsequent debates to come in legislatures and courts across the country. For instance, *The Globe and Mail* recently reported that a prosecutor in Alberta struck a deal with a pregnant woman accused of trafficking in cocaine (Cheney and Philip, 1998). She agreed to plead guilty and remain in custody pending her sentencing, which would occur after the birth of her child. Her sentence, when pronounced, would amount to one day. The prosecutor and judge reasoned that, although the overall sentence would be lighter than usual, the procedure supposedly enabled the woman to refrain from drug use during the remainder of her pregnancy (although jails are known for their availability of drugs) and yet be able to care for the child upon its birth. The two reporters covering the story note that this case differs from that of Ms. G., who was held against her will, whereas the defendant in this case agreed to the deal. It is difficult to determine whether she agreed or simply viewed it as means to a shorter sentence. To benefit from the deal, she had to plead guilty and another set of issues then arise. Whether the Supreme Court decision and the publicity surrounding it influenced this particular prosecutor and judge is not known. Nonetheless, the confluence of confinement in a facility such as jail and abstinence from drug use was featured in the arguments in both cases.

This last point is worth underscoring. Arguments emerging from the Supreme Court of Canada are accorded much authority, even by those who may oppose them. The Supreme Court, as its name implies, is the highest legal decision-making body in the country. Academics and others writing about the issues in different ways will not be accorded the same publicity and influence.

There is perhaps one other point worth mentioning about the Supreme Court decision and its influence on our understanding of substance use and pregnant women. Referring the matter of fetal rights to the legislature, as the Supreme Court decision did in its Majority decision, underscores its belief that only if we establish whether the fetus has rights, can we entertain a case such as this. From this assertion, it is easy to suggest that if we are to assist the fetus, it must have rights in law. Conversely, if the fetus has no rights, then we are not able to help it develop in a healthy manner when the mother does not take care of herself during pregnancy. Those wishing to protect fetal development may understandably focus their energies into lobbying legislators. Keith Martin, Reform M.P. for Victoria, has already drafted a private members' Bill, advocating for such federal legislation, although legislators, knowing the passions and difficulties provoked during the abortion dispute, may be reluctant to tackle the issue. Those who do not want such legislation appear to be unconcerned about fetal health and seem to be blindly supportive of women's rights. Rights of the fetus and rights of the mother are pitted against one another. There seems to be no common ground, nor a forum from which to make progress on the issue unless the logjam of whose rights should prevail is first broken – an unlikely event.

The Data and Analysis of the Factums

This section analyses how the problems and solutions of women who use substances during pregnancy are framed in the factums of both the Appellant, Winnipeg Family and Children's Services, and the Respondent, Ms. G. These factums are composed of three parts: the Statement of Facts, the Points in Issue and the Argument. Each of these will be reviewed to demonstrate how the problems are presented from the outset in the Supreme Court deliberations.

The Statement of Facts

The Appellants begin their argument with a highly descriptive Statement of Facts culled from the Case on Appeal document. Of the 14 facts presented, 12 of these focus on developing a detailed chronology of Ms. G.'s use of solvents, applying the following terms in each fact: "abusing solvents," "addiction problem," "smelling of solvents," "inhaled solvents," "influence of solvents," "exposure in utero to solvents," "sniffing solvents," "chronic sniffer," "smell of glue," "dried glue" or "withdrawal from solvents." Addiction to smelling solvents conveys a particular meaning that is different than "drinking martinis" or "sniffing coke." In North American culture, solvent use is associated with the addiction problems of children, the very poor and isolated, and First Nations peoples, particularly since the wide publicity given to the community of Davis Inlet.[1,2] Indeed, because solvents are cheap and easily obtainable, they are used most frequently by these groups. Glue sniffing thus becomes an activity of some of the most powerless people in our society. By combining children with First nations people, the judgment and capacity of First Nations people is reduced and the image of people who "do not know better" – i.e., those who require firm guidelines by benevolent authorities – is conjured up through a cultural script. Although the Appellant's Statement of Facts makes no mention of Ms. G.'s First Nations heritage or her poor economic and social situation, the powerful and repeated description of her addictive behaviour implies both.

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[1] Davis Inlet in Labrador was home to the Mushaau Innu, who gained national publicity because of solvent inhalation by many community members, including children, in the mid-1990s. The 500-member community is in the process of moving to Natuashish on the Labrador mainland, closer to their traditional hunting grounds and is re-developing their community.

[2] For instance, the American Academy of Pediatrics policy statement on inhalant abuse is written by the Committee on Substance Abuse and the Committee on Native American Child Health. It cites the causes of inhalant abuse as "peer pressure and dysfunctional families" and indicates that although it cuts across cultural and economic groups, it is more prevalent among those with low income and among Hispanic and Native American children and adolescents.

I am not arguing that Ms. G. did not sniff solvents, nor that doing so did not lead to serious problems for her. What is important is how her addiction is described in repeated, detailed and negative terms at the beginning of the Appellant's factum with emphasis on the type of addictions that supports the court taking action on behalf of the fetus.

The second theme, evident in 11 clauses, emphasizes Ms. G.'s selfish willfulness and her inability to be a parent, again reinforcing her childishness. This theme is developed by tracing her history of parenting, from the birth of her first child and her inability to improve at a residential facility to assist young mothers (clause 2), her lack of opposition to an order of permanent guardianship (3), her consent to a permanent order for her second child (4), the apprehension of her third child at birth and her blatant use of solvents before and after this birth (5, 6, 7), her refusal of treatment (8), the serious impact of drug use on her children (9), her lack of prenatal care (10), her use during pregnancy (11) and her refusal of treatment again (12). In all but one of these situations, Ms. G. voluntarily behaves in a way that is damaging to her children. For instance, she was "unable to stabilize her lifestyle" (2), she "arrived at the hospital smelling of solvents" (5, 6) and she "consistently refused all offers of treatment" (8, 12).

The third theme (10 clauses) describes the efforts of various agencies to help Ms. G., and protect her children, and her refusal and/or inability to benefit from these efforts. On the one occasion that Ms. G. sought help herself (10), she went to the hospital for her own medical needs, not for those of her fetus. The efforts to help her face her problems were wide-ranging, including a residential facility for young mothers (2), visits from agency social workers (4, 8, 12), apprehension of her children (3, 5, 6, 7), hospital care (10, 11), offers of residential substance-abuse treatment (12) and, finally, mandatory confinement in a medical facility (14).

As the Appellant intends to argue that the court has the jurisdiction and obligation to take action in this case and should do so because of the *extenuating* nature of this particular situation, it is important for the Appellant to convey a highly unfavourable image of Ms. G. from the outset – not as a victim of circumstances but as a willful protagonist in her own destruction and in inflicting damage on her fetus. She emerges from this description as an incorrigible child.

On the other hand, the Respondent plans to focus on the limits of the law with regard to fetal rights. Its language and tone of is very different: crisp, business-like, and focused primarily on existing law. The Statement of Facts, nine sections in all, makes only two mentions of addictions: that Ms. G. "had a history of chronic solvent abuse" and that she had an "abuse problem." The Respondent mentions only the most recent pregnancy and, "according to the Appellant's social workers," her one refusal to enter treatment. The Respondent's text provides a detailed chronology of the history of the case in court (seven clauses) and focuses particularly upon the behaviour and thinking of the original judge regarding the use of the *Mental Health Act* and the doctrine of *parens patriae*. As the Respondents do not intend to base their case on solvent use and its effect on the fetus, they do not feel the need to present a sympathetic view of Ms. G. and emphasize her strengths.

Thus, the opening and highly unflattering description of Ms. G. by the Appellant stands as one of the few mentions of her in the entire set of documents. Who she is, her circumstances, the situation leading to her use of solvents and so forth are simply not included because this information is not material to the argument of either side. However, as it is the opening statement by the first brief, the Appellant's description sets the overall message about Ms. G. by which subsequent text could be read.

The Points in Issue

After the Statement of Facts, the two factums turn to the legal points in issue. The Appellant framed these legal points in the following questions:

1. Does a birth mother who has chosen to carry a fetus to full term owe a duty of care to that fetus?

2. If the answer to Question 1 is "yes," in what circumstances, if any, should a court intervene to enforce compliance with the duty of care?

The first question begins with the assertion that a pregnant woman is a "birth mother." The term "birth mother" is a curious one, used in popular language to distinguish biological mothers from adoptive ones and presumes that the child is already born. The use of the term is important for the Appellant's argument: if a pregnant woman is a mother, the fetus must be a child. There is also the assertion that a woman who carries a fetus to full term has chosen to do so. This assumption ignores the reality of the lives of many women, the nature of addictions and the lack of universal access to abortion. It obscures the very real differences in opportunities among Canadian women and makes them appear equal. It also presents women as free and independent agents without relationships that might deeply influence their decisions, particularly as they relate to pregnancy. However, there is some logic in emphasizing choice in this matter, as those supporting abortion – those arguing for women's rights – have called themselves "Pro Choice" and have campaigned using the slogan "women's right to choose." If women can choose abortion, why is it not logical to assume that if she doesn't choose abortion, then she must have chosen a full-term pregnancy? The use of the active voice throughout the questions reinforces the message of a free and independent woman and places emphasis on her choices. If the question read, "Is a fetus who has been willingly carried to term by a birth mother owed a duty of care by that birth mother?" its impact on creating this impression would be considerably less.

This assumption of equal and independent Canadian women is important to the second part of the question – does she owe her fetus a "duty of care"? This phrase has legal meaning within the argument of the Appellant, as it is a phrase used in tort law to define responsibilities between legal parties. It is here that the Appellant introduces the notion that the fetus is a legal entity. Although it would not be impossible for the Appellant to name others as owing a duty of care to a fetus (e.g., fathers or the state), only the mother is mentioned. The statement also implies that women have equal capacity to provide that care as no circumstances are mentioned that would qualify the duty (given resources, health and ability). Thus, if women have responsibility and capacity to care, then their failure to do so must relate to their unwillingness. This particular clause also sets up the dichotomy between a woman and her fetus. Moreover, it is assumed that a duty of care will benefit the fetus, otherwise why would it be brought before the court? Thus the well-being of the fetus is linked to the woman's willingness to carry out her duties.

The second question directs our attention to the first question with the phrase "if yes." Only if we agree with the first question does the second make any sense and thus it urges us to accept the underlying premise of the first question: that women who do not care for their fetus are simply unwilling to do so and have made that choice. It then directs our attention to the "circumstances," if any, that would indicate an intolerable dereliction of duty. Given the account of Ms. G. provided in the Statement of Facts, a more damning description of dereliction of duty is difficult to imagine. By raising the question of "what circumstances," it implies that these can be named and somehow quantified. There is also the implication that agreement could be achieved on these circumstances. Court intervention is proposed as the solution for the problem of recalcitrant mothers, just as it is for those who fail to abide by other laws, thus making clear the connection between mother's behaviour and unlawful behaviour. There is the further suggestion that court intervention could "force compliance" of women and thus solve the problem.

The first question draws our attention to the similarity of Canadian women in terms of their resources, capacities, freedom to act and maternal duties. The second question requires us to distinguish between these women on one dimension only: their unwillingness to carry out their duties, and to have faith in the court's ability to make women "behave." The questions are based on a fundamental premise that individual women have the responsibility to care, on their own, for themselves and their children. They eliminate any consideration of social responsibility and the inequalities in Canadian society that make it patently unfair to base judgments upon individual efforts alone.

The advantage of being in the position to define the problem is considerable. It immediately focuses attention upon certain issues and leaves others aside. It sets the stage for defining solutions.

The Argument: Defining the Problem

The third section of the factums set out the answers to these two questions. The factum for the Appellant identifies the behaviour of women and its impact on the fetus as the problem to be solved. Recognition of fetal rights and court intervention to protect these rights is viewed as the solution. According to the factum of the Respondent, the problem before the courts is the solution of the Appellant: granting recognition of fetal rights and using the court to enforce these. The solution of the Respondent is to wait for legislative change before recognition of fetal rights. As the factum states:

> Essentially, the Appellant is asking this Court to create an entire legal regime from the creation of the right, to the rules of evidence and procedure involved in exercising the right, to the enforcement mechanisms for any court rulings. Respondent submits that the Appellant is asking this Court to take on the role of the legislative branch... (15).

The Appellant addresses the first question – "Does a birth mother who has chosen to carry a fetus to full term owe a duty of care to that fetus?" – by first establishing what is normative behaviour during pregnancy. The opening sentence begins with a reference to professional authority, asserting that "medical technology" has provided "valuable information" about the harmful impact of substance use during pregnancy and that this information is widely known to women (15). It then contends that most women pay attention to this during pregnancy. Even some addicted women recognize the importance of this norm and change their behaviour during pregnancy, implying that addictions are possible to control if a women cares enough about the health of her fetus (16). The Appellant quotes findings from a U.S. study in which 80 percent of drug-using mothers in New York City "reported concern for their child as the motive for decreasing or stopping drug use during pregnancy" (15). In spite of this, the argument continues, many children are born harmed by substances, most likely alcohol (17, 18), indicating that there are seemingly many women who choose to continue taking substances (the argument is inconsistent on this point). The argument then invokes the support of many groups, including First Nations groups (19, 20), and calls attention to the numbers of First Nations children and those in the care of children's aid societies suffering from Fetal Alcohol Syndrome (FAS) and Fetal Alcohol Effects (FAE) (20, 21).

Thus, the problem becomes the behaviour of some "mothers" who have chosen to have children, have chosen to continue taking substances and have chosen to ignore well-known medical facts. The argument makes clear that what is being discussed is a "mother's" right to make these choices, versus the health of the fetus:

> The fundamental question, therefore, becomes which of the two outcomes is the less of the two evils. Should we as a society protect and defend the absolute right of the mother, recognizing that in some situations this will result in a permanently damaged child, or should the rights of the mother be curtailed, in narrow and defined circumstances, so as to limit the risk of permanent disability to the child that she has decided will be born? (55)

The argument of the Respondent gives short shrift to addressing the issues of women's use of substances during pregnancy and the rights of women to make their own choices. Instead, it belittles the above arguments by pointing to the numbers of behaviours that could also cause damage: smoking, exposure to second-hand smoke or living with a violent spouse and thus "open the floodgates" (41, 42, 43, 44, 45, 46). These examples, rather than challenge the Appellant's view of women's behaviour, actually reinforce the view that some women do harmful things during pregnancy. Thus, the assertions about marginalized women, their "choices" and the rights of women are left unchallenged.

Although the factum of the Respondent does not deal with the perception of a "mother's rights to make bad choices for the fetus," it does discuss women's rights to freedom of movement. In a brief discussion (two clauses), the Respondent argues not so much on behalf of women but of all citizens. The first sentence in the argument mentions "women," the next "people," the next "a person" and concludes:

> The Respondent takes the position that forced medical treatment and forcible confinement of *mentally competent adults* [emphasis added] who are not engaged in illegal activities is an extreme prima facie breach of personal liberty (49).

In a later part of its factum, the Respondent returns to the issue of freedom and its guarantee under Section 7 of the Canadian Charter of Rights and Freedoms (53). It poses the problems of ensuring procedural fairness in cases such as this so that the intent of the Charter is not breached. For instance, there is a need for a speedy process if anything is to be accomplished for the fetus. Yet there is also a requirement for an impartial and thorough process, which is every citizen's right. However, the Appellant does not let this notion remain unchallenged. Using statements of Judge Sopinka on fundamental justice, the Appellants argue that a system of procedural fairness is entirely feasible, based on due process and least intrusive measures.

Thus, in the end, "mothers'" rights in the Appellant's argument are narrowly defined as the right of a woman to choose a destructive and shallow life that harms herself and helpless others. There is no mention of her right to adequate income, health care, employment or educational opportunities. The number and kind of "mothers" who wish to exercise this right are not defined explicitly and the only mention of these mothers implies that they are primarily poor women and women of First Nations heritage. This perception of rights is not challenged by the Respondent.

The Argument: Defining the Solution

The heart of both factums focuses on the legal precedence of fetal rights separate and apart from the woman that is carrying it. The Appellant cites laws and decisions that have given rights to children for damages occurring in utero and urges a small extension in the law to protect "the chosen" fetus. The Respondent argues that although there is precedence granting live children rights for damages occurring in utero, there is no capability in law to give them rights prior to their birth. In fact, the opposite decisions have been made consistently. It argues that granting such rights in this case will open up a legal Pandora's box where all sorts of other issues, namely the abortion debate, will be up for grabs.

The Appellant first introduces its solution to the problem – recognition of fetal rights and court intervention – by referring to examples in the U.S. where courts have authorized medical interventions and hospital detention against women's wishes to benefit the fetus (24, 25). U.S. legislation authorizing mandatory reporting of fetal exposure to controlled substances, voluntary services and mandatory confinement in a chemical treatment facility is then mentioned (26). Citing U.S. precedence is a risky strategy. For some Canadians, the fact that it is done in the U.S. is sufficient reason not to do it in Canada, given the vast differences in population and social policies. Canadians pride themselves on their more compassionate and orderly society. On the other hand, the actual existence of court action and legislation in a powerful and nearby nation can provoke nationalism in another sense: not to be "behind the times." Citing a highly prestigious authority is the approach used by the Appellant in defining the problem (the profession of medicine) and in proposing the solution (the U.S. courts).

The Appellant then returns to the notion of "women's choice" and asserts that the only fetus to be protected by law are those where "the mother had the intention to carry the fetus to term" (27). This assertion is important to the Appellant's argument to ensure that the abortion question does not re-emerge. The Respondent speaks passionately about the absurdity of one fetus having legal rights to sue (even if it was never born) based solely on the mother's intention to deliver it, "something which could change at any time for any number of reasons," while another fetus whose mother did not intend to carry it to birth would have no such rights. From the beginning, the Respondent opens up the abortion issue, citing Tremblay v. Daigle (1989) and quoting from the written judgment of the case. In effect, if we offer legal rights to some fetuses, then there is no justification to say that we should not offer them to all fetuses. We cannot on one hand permit abortion and on the other give fetuses rights. Connecting this issue to the abortion debate is a powerful legal and emotional strategy. It links it with all of the failed court cases, the rhetoric and agony experienced by court officials, legislators and the general public.

The Respondent also enlarges the issue immediately, from the discussion of this particular case to the ramifications that would occur in other parts of law:

> It is submitted that it would be difficult to conceive of a legal issue that has more potential complications, permutations and implications than the one under consideration here. At minimum, any change in the law would potentially impact every woman who is, or will become, of child bearing years, More likely, however, such changes would impact on every citizen in Canada... (30).

Although effective from a legal point of view, the strategy has the effect of ignoring the problem at hand and appearing unconcerned about the problems of FAS and FAE. This is particularly true when the Respondent compares the fetus to "any other body part," underscoring the absurdity of enforcing duties of care to one body part and not another. While logical in one sense, the arguments seems cold and inherently lacking in common sense and concern for children. In effect, the Respondent argues that we should not recognize fetal rights, because it will cause all sorts of legal problems and difficulties, not because it is wrong to do. This ambiguous message is furthered when the Respondent's solution is proposed.

Although it appears that the Respondent challenges the advisability of incarcerating pregnant women, a careful analysis of the text indicates that it does not. Instead, the Respondent argues the difficulties in determining which harmful behaviours should be curtailed (43, 44), the difficulty in determining these (45, 46), and the difficulty of establishing and enforcing remedies (47–62). Because the Respondent is arguing that the court has no jurisdiction to deal with fetal rights, it claims to have no opinion on whether the fetus should be granted rights now or in the future, nor whether those rights should be exercised by demanding particular conduct of its mother. For example, the Respondent states that, *for social policy reasons*, a legislature, without seeking to interfere with a woman's access to abortion, *might* choose to pass legislation that requires certain standards of conduct for pregnant women... (28). The Respondent's solution to the situation is to refer the matter to the legislature, the proper forum for deciding such matters. Referring the matter to the legislature and concurring that legislative action may be both possible and useful, the Respondent gives credibility to the Appellant's argument in one sense, although denigrating its appropriateness in the court forum on the other hand.

Summary of the Factums

The factums have provided two very different definitions of the problem and solution. The Appellant argues that the problem is lodged in the willful and damaging behaviour of a small number of pregnant women and that the law is sufficiently flexible to allow for their detainment while meeting the demands of the Charter of Rights and Freedoms. The Respondent argues that the problems inherent in detaining such women are so extensive given present law that the solution is to refer the matter to the law-makers and let them tackle the thorny issues. In making their arguments, both Appellant and Respondent have left many assertions unchallenged. A few are selected that relate particularly to the original research questions and these are summarized below. These will form the framework for the analysis of the Supreme Court decision, both the Majority and Minority reports, to determine the extent to which they are addressed. While these assumptions will serve as a starting point, it is not the intention to analyse the Supreme Court decision in the same detail as the factums because these documents are similar. Some important assumptions from the factums include:

Connecting addictions and fetal harm:

- that glue sniffing during pregnancy has a permanent impact on fetal development and child health and that medical science can prove this; and
- that glue sniffing during pregnancy is a "lifestyle" choice, freely selected by thoughtless women, and that addictions treatment for such women is readily available.

About inequality:

- that there are no particular and extenuating circumstances to explain Ms. G.'s behaviour;
- that women have equal access to choose abortion and freely choose motherhood if they do not abort; and
- that Canadian women have an equal capacity to care for their children and have the prime responsibility to do so.

About treatment and family support:

- that alcohol and drug treatment is freely available and that agencies such as the Winnipeg Child and Family Service have available and appropriate services for mothers like Ms. G. to help them care for their children.

About the benefits of mandatory intervention:

- that the health of the fetus will improve if women are incarcerated in some fashion.

At the same time, the two arguments have differed substantially on the notion of fetal rights, with the Appellant citing extensive law indicating why fetal rights could be extended in this situation, and the Respondent indicating why no such rights exist in law.

The Data and Analysis of the Supreme Court Decision

The Supreme Court decision contained 142 clauses, 59 of which outlined the Majority opinion (Lamer, La Forest, L'Heureux-Dube, Gonthier, Corry, McLachlin and Iacobucci) and the Minority opinion, which is contained in the remaining 80 clauses (Major and Sopinka). The decision is organized similarly to the factums with a Statement of Facts, the issues or judgments to be reviewed, the analysis and the conclusion. The Majority and Minority reports connect closely with the arguments set forward in the factums. The Majority report argues the case on three questions of law:

1. Does the law of tort permit an order for the detention and treatment of a pregnant woman for the purpose of preventing harm to the unborn?
2. Does the power of the court in *parens patriae* support an order for the detention and treatment of a pregnant woman for the purpose of preventing harm to the unborn child?
3. Constitutional concerns: The Majority report answers "no" to the first two questions and does not address the third, "will the Canadian Constitution permit such an order?", given the negative answer to the first two questions.

   The Majority report concludes:

> ...that the common law does not clothe the courts with power to order the detention of pregnant women for the purpose of preventing harm to her unborn child. Nor, given the magnitude of the changes and their potential ramifications, would it be appropriate for the courts to extend their power to make such an order. The changes to the law sought on this appeal are best left to the wisdom of the elected legislature. I would dismiss the appeal (SCD Majority report, p. 59).

The Minority report contends that the doctrine of *parens patriae* can be applied to this case and others like it, concluding:

> To grant the limited intervention proposed in this appeal serves the interest of:
>
> a. the mother as her option for an abortion is always available,
> b. protecting the fetus from serious and irreparable harm and permits it a reasonable chance of having a normal life after birth,
> c. preventing unnecessary spending by Canadian governments to permanently care for the mentally disabled child born as a result of the mother's unrestricted drug addiction.
>
> I would allow the appeal, and declare that Schulman J. was within his jurisdiction under parens patriae to order the respondent to refrain from the consumption of intoxicating substances, and to compel the respondent to live at a place of safety until the birth of her child (SCD Minority report, p. 141).

The next section will not examine these decisions themselves but rather look at how the assumptions made in the factums were challenged and/or reinforced in the Supreme Court decision in both the Majority and Minority reports.

Connecting Addictions and Fetal Harm

The Supreme Court decision (Majority and Minority opinion) makes the direct connection between solvent use and permanent disability to the fetus, taking the assertions of the factum of the Appellant even further.[3] The Majority opinion opens the summary of its argument with the following statement:

> In August 1996, the respondent was five months pregnant with her fourth child. She was addicted to glue sniffing, which may damage the nervous system of the developing fetus. As a result of her addiction, two of her previous children were born permanently disabled and are permanent wards of the state (SCD summary).
>
> She stopped sniffing glue and in December gave birth to an apparently normal child, which she is now raising (SCD Majority, p. 2).

At the time of the Supreme Court decision, the child would be six months old, far younger than Ms. G.'s other children. The prospects of determining the effects of any glue sniffing on a child of this age would be very difficult, yet this is not mentioned.

The Minority opinion also makes the same direct connection between glue sniffing on the part of the mother and permanent disability of the child. A comparison of Clause 68 to 87 of the Supreme Court decision (Minority report) with clause 2-14 (Appellant's factum) indicates that all the facts submitted about Ms. G. by the Appellant are included in the Supreme Court decision. However, a few more are added, including the statement that her second child was born "permanently disabled" and her third child "was also permanently disabled" (SCD Minority report, clause 70). These statements are not referenced and no evidence of examination of these two children is presented. The Minority report concludes with the statement that mandatory treatment should be allowed to prevent:

> ...unnecessary spending by Canadian governments to permanently care for the mentally disabled child born as a result of the mother's unrestricted drug addiction (SCD Minority report, clause 141).

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[3] The Appellant's factum seems much less certain of making a direct connection than these statements contained in the Supreme Court decision, mentioning only "global developmental delay" as the symptoms exhibited by her two children and not some of the other and more serious side effects that are apparently possible. In its factum, the Appellant mentions the connection of solvent use and fetal development in two clauses:

> Developmental assessments done of DFG's second and third child while they were still within the care of the Agency showed that both children displayed signs of global developmental delay. Developmental delay is a birth defect found in children exposed *in utero* to solvents (Case on Appeal, pages 22, 37) (10).

and

> Dr. Albert Chudley, a Professor of [sic] in the departments of pediatrics and human genetics testified via affidavit that organic solvents used by chronic sniffers are neurtoxic to the brain of the fetus. Children exposed *in utero* to such substances may exhibit central nervous system dysfunction, development delay, attention deficit disorder and microcephaly. Animal studies have shown that chronic exposure to solvents can lead to fetal growth and developmental retardation and to fetal death (13).

The Respondent does not refer to this matter at all, only that she had a "history of chronic solvent abuse" and was "twenty-two weeks pregnant" at the time of the Winnipeg Child and Family Service's intervention.

The Supreme Court judges appear to accept the conflation of "global development delay" with "permanent disability" and to connect the two to the intake of substances.

There is a caveat to these overall remarks. The Majority decision does indicate in another clause that the two children were "injured" because of the mother's glue sniffing (5) and makes later reference to the fact that the science of:

> ...determining what will cause grave and irreparable harm to a fetus – the threshold for injunctive relief – is a difficult endeavor with which medical researchers continually struggle. The difference between confinement and freedom, between damages and non-liability, may depend on a grasp of the latest research and its implications (SCD Majority report, clause 40).

It is not my intention to deny the seriousness of substance use on a developing fetus. However, it is important to underscore that the Supreme Court decision did not add a great deal, if anything, to our understanding of the difficulties in determining the actual impact on any one child of its mother's ingestion of particular substances. The science is a rudimentary one, requiring more effort and attention. Most is known about the impact of alcohol and little about solvent use, at least on the developing embryo. Because glue sniffing affects the most disadvantaged women, research on its impact may have had less priority. To assume that we "know" is to ignore the need for much more work in this area.

Addictions are a Lifestyle Choice

It is not surprising that the subject of addictions is raised infrequently in the text, given the nature of the arguments mounted on each side. The Majority opinion bases one of its strongest arguments against incarcerating women for substance use on the spectre of the "slippery slope" – if substance use is to be punished, what substances (tobacco, alcohol, second-hand smoke, etc.), what amounts what behaviours apply?

> A woman could...be held liable for any behaviour during pregnancy having potentially adverse effects on her fetus, including failing to eat properly, using prescription, nonprescription and illegal drugs, smoking, drinking alcohol, exposing herself to infectious disease or to workplace hazards, engaging in immoderate exercise or sexual intercourse, residing at high altitudes for prolonged periods, or using a general anesthetic or drugs to induce rapid labour during delivery (SCD Majority report, clause 39).

A whole section of the Majority opinion is entitled "(c) Recognizing a Cause of Action for Lifestyle choices which may adversely affect others" and begins with the following statement:

> If the problem of permitting an unborn child to sue its future mother could be surmounted, a further difficulty presents itself. Could the unborn child sue her for lifestyle choices?... To date, courts and legislatures have confined the right to the child suing its mother for prenatal injuries to injuries due to motor vehicle accidents (SCD Majority report, clause 30).

The use of the term "lifestyle choices" to describe substance use and other activities occurs 12 times in the Majority argument. In this argument, addiction to substances is translated into drinking and connected to a series of other activities that are contraindicated in pregnancy. These activities are seen most often as choices over which people may have more control, rather than pathological or deviant behaviour. Although the understanding that many factors contribute to a healthy pregnancy outcome is reflected in this argument, the grip and nature of serious addiction to any potentially harmful behaviour is minimized.

Downplaying the power of addictions also supports one of the main arguments contained in the Minority report. This argument contends that, as Ms. G. and others like her willfully make choices that harm the fetus, they should be confined against their will:

> Since a pregnant woman has the right to decide her lifestyle, a court's ability to intervene to protect the fetus must be limited to extreme cases where her conduct has, on proof to the civil standard, a reasonable probability of causing serious irreparable harm to the unborn child (SCD Minority summary).

The Minority report also argues that the doctrine of parens patriae, the authority for child welfare legislation, can be used to support court intervention in this case and thus it is to their advantage to portray mothers as "child abusers":

> The parens patriae jurisdiction of the superior courts is of undefined and undefinable breadth. This Court's decision in Eve (Mrs.) V Eve, [1986] 2 S.C.R. 388, indicates that inherent power resides in the provincial superior courts to act on behalf of those who cannot act to protect themselves. A fetus suffering from its mother's abusive behaviour is particularly within this class and deserves protections (SCD Minority report, clause 91).

There is again a caveat to the above remarks. Although neither side gave much attention to addictions, the Majority report does make mention of their power and destructiveness:

> This is not a story of heros and villains. It is the more prosaic but all too common story of people struggling to do their best in the face of inadequate facilities and the ravages of addiction (clause 5).

The Majority report also discusses addictions and their cause, however briefly, when arguing that the legal sanction of tort may not be effective:

> A further problem arises from the fact that lifestyle "choices" like alcohol consumption, drug abuse and poor nutrition may be the products of circumstance and illness rather than free choice capable of effective deterrence by the legal sanction of tort.
>
> Treating pregnant substance abusers as fetal abusers ignores the range of conditions that contribute to problems like drug addiction and lack of nutrition, such as limited

> quality pre-natal care, lack of food for impoverished women, and lack of treatment for substance abusers (SDC Majority report, clause 41).

About Addictions Treatment and the Benefits of Mandatory Intervention

The issue about the availability of pertinent treatment for pregnant women is not mentioned in the decision except very briefly in three already-noted places: where the Minority report indicates treatment with cultural sensitivity was offered Ms. G. (81), and the Majority report notes inadequate facilities (5) and a lack of treatment (41). However, because the Minority report repeats all of the details contained in the Appellant's Statement of Facts, the impression is left that in this particular case, alcohol and drug agencies and child welfare services "went the second mile" for Ms. G., with no discernable results. Without any full discussion of the actual range of services available and the serious inadequacies in treatment approaches for pregnant women, the impression remains that the problem resides within the addict, not the treatment system nor the community at large.

The benefits of mandatory confinement or treatment received a spirited debate in the Supreme Court decision. Both reports accept that Ms. G. quit using substances upon entering the treatment facility and apparently gave birth to a healthy infant (Minority report, 129; Majority report, 2). Building upon the success of this case, the Minority report further argues that confinement is for treatment, not punishment in an appropriate medical facility, and that a "mother" could be free to refuse treatment and remain there, free from harmful toxins if not taking treatment (Minority report, 125). The Majority report challenges this notion as simplistic, citing the problems of women being watched by their friends and family, therefore isolating them from support (42). It further argues that the actions may "drive the problems underground" and may persuade women to have abortions, stating:

> Women under the control of a substance addiction may be unable to face the prospect of being without their addicting substance and may find terminating the pregnancy a preferable alternative. In the end, orders made to protect a fetus' health could ultimately result in its destruction (44).

Readers are clearly left with the impression that, while it may have worked in this circumstance, the issue of mandatory treatment is far from a simple solution and may have serious drawbacks.

About First Nations Peoples and Women

The fact that Ms. G. is a First Nations woman is not mentioned at all in the Majority report. The only acknowledgment of the importance of race occurs in the context of who would be most affected by any law to detain pregnant women:

> The difference between confinement and freedom, between damages and non-liability, may depend on a grasp of the latest research and its implications. The pregnant women most likely to be affected by such a "knowledge" requirement would be those in lower socio-economic groups. Minority women, illiterate women, and women of limited education will be the most likely to fall afoul of the law and the new duty it imposes and to suffer the consequences of injunctive relief and potential damage awards (SCD Majority report, p. 40)

Although the statements above are probably accurate, they do not provide any explanation why such women would be most affected by any law. For instance, the reader could easily conclude that "minority women, illiterate women and women of limited education" are more likely to use substances during pregnancy. The other conclusion – the connection between poverty and the inability to afford good legal assistance – is not as obvious. The term "minority women" is very imprecise and presumably includes all women who are not European. The circumstances facing Aboriginal women and those from other racial and cultural groups in Canada are vastly different, yet these distinctions are not raised. There is another assumption: if these women are poor and marginalized anyway, what is the point of going after them for damages to their fetus?

The Minority report refers more directly to Ms. G.'s First Nations heritage. The first reference describes the alcohol and drug treatment program available to Ms. G. as having a "strong cultural content for Aboriginals" (81). The main references, however, refer to the "crisis situation" in many Aboriginal communities concerning FAS and FAE, citing two Manitoba studies (Moffatt et al., 1996; The Manitoba Children and Youth Secretariat, 1997). Support for the evidence of this crisis comes from The Manitoba Tribal Council NADAP Coordinators and Treatment Directors Committee (the alcohol and drug staff), from an unidentified person testifying to the Royal Commission on Aboriginal Peoples, and the Southeast and West Region Child and Family Services, the child protection agencies responsible for 18 First Nations communities in Manitoba. The latter agencies had intervener status and urged the court to develop:

> ...a legal remedy to use in their fight against FAS/FAE. These interveners submitted that such a remedy would be consistent with the Aboriginal world view, and that the common law should be expanded to help alleviate what is particularly an Aboriginal problem (SCD Minority report, 88(v)).

The Aboriginal voices that are acknowledged in the Minority report are professionals working in the fields of drug and alcohol addictions in one province and an unacknowledged presenter to the Royal Commission. Their opinions are important but come from a particular vantage point. The text gives the impression, however, that there is consensus among Aboriginal people about the crisis and mandatory treatment. No other mention is made of Aboriginal peoples.

Nothing could be more damaging to the understanding of "the crisis" facing Aboriginal peoples than the above statements. They are made without any mention of the history of colonization in Canada, the lengthy legal, economic, social and personal abuses that Aboriginal people have endured, and their struggles to recover from this damaging history. The crisis is framed as Aboriginal women having damaged babies "and there is no indication the rate will slow down" (SCD Minority report, 88 (iv)). Extrapolating the voices from a few Aboriginal people to imply that there is an "Aboriginal position" on this issue, diminishes their vast differences and treats them as one group. The advances that many Aboriginal communities have made on this issue are lost. The vast differences of opinions among communities and people on a host of other issues are also forgotten. The stereotypes are further set in stone.

About Fetal Rights

One of the most powerful arguments launched by the Minority report connects the advancement of medical technology with fetal rights. Although the argument by the Appellant did not make much of the "born alive" rule, it is noteworthy that the Appellant's argument foreshadows this discussion as it opens with the following statement:

> Medical technology has provided valuable insights into the development of the fetus from conception to birth. This has provided much positive information.

The Minority report begins on Clause 60 and ends at Clause 142, thus including 80 clauses, of which 18 (102–120) focus directly on the "born alive" rule. Here the report challenges the notion that the "born alive" rule should apply in present-day jurisprudence because of the enormous advances that have taken place in medical science regarding fetal development:

> Present medical technology renders the "born alive" rule outdated and indefensible. We no longer need to cling to an evidentiary presumption to the contrary when technologies like real time ultrasound, fetal heart monitors and fetoscopy can clearly show us that a fetus is alive and has been or will be injured by conduct of another. We can gauge fetal development with much more certainty than the common law presumed. How can the sophisticated micro-surgery that is now being performed on fetuses in utero be compatible with the "born alive" rule? (109)
>
> However, there is the temptation to assume that the courts of the past that treated the "born alive" rule as one of the substantive law knew as much as is known today about fetal development. Since medical technology has improved to the point of eliminating nearly all of the evidentiary problems from which the "born alive" rule sprang, it no longer makes sense to retain the rule where its application would be perverse (110).

The Majority report does not address the above assertions, stating only that of two arguments favouring the extension of legal rights to the fetus, the one concerning "there is no defensible difference between a born child and an unborn child" is "essentially a biological argument" (25). Thus, the argument launched for public debate is a powerful one, whereby advances in medical science have now blurred the distinction between unborn and born to the extent that it makes no sense to maintain these distinctions in law. A fetus can now be a patient and, according to some, a student; thus, it should be able to be considered a litigant. These same technologies are now keeping people alive who would have died in the past, extending and confusing our definitions of life itself. Pregnant women are experiencing the blurring of these distinctions: a pregnant woman told me recently that she did not wish an ultrasound and, having been persuaded to have one, did not wish to know the sex of her child. She noted that her friends are now naming their child before birth, carrying pictures of them and talking about them as if they were born because of ultrasound technologies. Whether indeed the "born alive" rule will be able to withstand these advances is unknown but appears unlikely.

About Women's Rights

The single most damaging assumption made throughout the Supreme Court decision is the reduction of women's rights to the prerogative to lead their own "lifestyles." Lifestyle includes what they do, where they go, what they ingest and with whom, and so forth. While the rights to freedom of movement are indeed crucial, the conflagration of that right with all of women's rights overlooks the many other rights that have been fought for, including the right to vote, to claim pensions, to regain status as Indians and so forth. Further, the notion that women who have the right to move freely will do things that harm their children supports a longstanding battle that women have waged concerning their own independence and its effect on children. Probably the most enduring stereotype about feminists is that they value their own freedom more than caring for children and families and that one necessarily negates the other. The notions of women's rights that were depicted in the Supreme Court decision continues these myths.

Concluding Remarks

Without doubt, the Supreme Court decision has advanced thinking on the issue of pregnant women and substance use in several ways. Although there were many differences between the Majority and Minority reports in the Supreme Court decision, there was some agreement on the nature of the problem. Although, in contrast with the Minority judgment, the Majority report indicated that the granting of fetal rights would present a considerable problem under existing law, the Majority decision did not state that nothing should be done about the issue of women using substances during pregnancy. Instead, it referred the matter to the legislature. The Minority report contained strong exhortations to tackle rather than ignore the same issue. Thus, the notion that "something should be done" is contained in both reports.

Whether that "something" should be legislation is unclear. Both reports indicated that there were problems in present and potential legislation. Even the Minority report stumbled on some of these problems in existing legislation, including the means to distinguish for which women and under what circumstances the laws could be enforced. The Majority report outlined some of the very contentious issues that would have to be addressed if legislation granting fetal rights was contemplated. There is a strong view expressed in the Majority report that mandatory confinement is unlikely to benefit the developing fetus, even if it were possible to design such legislation. The Minority report disagrees. Although both agree there is a problem, there is much less agreement about the possibilities of remedying the problem with legislation. Nonetheless, many of the thorny legal issues connected with fetal rights and mandatory incarceration have been aired in the decision.

The Supreme Court decision has also left a less uncertain legacy. It launched the potential for a controversial public debate on pregnant women and substance use by referring the matter to the legislature and by leaving intact a number of crucial assumptions. Although the Majority and Minority reports did not agree on all of these assumptions, they either challenged them weakly or left them uncontested because they did not pertain to their own arguments. These are listed below and provide a summary of the findings of this chapter:

1. That we know who Ms. G. is and have a comprehensive and accurate chronology of her situation.

2. That Canadian women are free and equal citizens who are able to decide on their own whether to have children and to care for them if they do.
3. That women who carry children to term do so because they wish to have a child. Otherwise, they could have an abortion, which is equally available to all Canadian women.
4. Although addictions can play a role in pregnant women's using of substances, the primary cause is their desire to pursue their own lifestyle. They are basically selfish and child-like, unable to think of others or the future.
5. That addictions are a lifestyle choice that includes a host of other choices: where to live, what to eat, wear, smoke, etc.
6. That women's rights are primarily concerned with their right to freedom, which conflicts with women's responsibility to care for her children.
7. That the fetus needs protection from willful and selfish mothers, and the state may be in a position to offer that protection.
8. That Aboriginal people have consensus on the problem of women using substances during pregnancy, agree it is a crisis, and agree on mandatory confinement.
9. That medical science is ahead of the law on two counts. It can now predict with some degree of certainty that alcohol and drugs harm the developing fetus in predictable, damaging and permanent ways, and it can demonstrate that the fetus is a living organism well before birth. The law that does not recognize fetal rights is ignoring these medical advances. Given these advances, the fetus is actually a child and a pregnant woman is a mother.
10. That although there may be some shortage of treatment facilities, pregnant women requiring help with addictions and support can receive it from provincial drug and alcohol and child welfare services.
11. That in a case argued before the Supreme Court, all of the relevant matters have been aired and the latest authorities have been used to debate the issues.

These are the assumptions that must be unraveled as we attempt to develop some consensus on policy alternatives for women who use harmful substances during pregnancy.

CHAPTER 3: MISCONCEIVING MS. G.: A CRITICAL DISCOURSE ANALYSIS OF THE CANADIAN PRINT MEDIA'S COVERAGE OF THE CASE OF MS. G.

By Deborah Rutman

Introduction

This chapter examines how substance use by pregnant women was discussed by the Canadian print media, as reflected in 10 major newspapers' coverage of the Supreme Court of Canada's case of Ms. D.F.G. (decision handed down on October 31, 1997). As Marilyn Callahan notes in Chapter 2, this Supreme Court case received a considerable amount of media coverage. In turn, the media's attention almost certainly has shaped public opinion regarding the issues. Given the media's influence on both public perceptions and policy debates, it is important to examine how the media reported on the "news story" of the Supreme Court decision, and to analyse the media's commentaries/editorials on the case.

This chapter thus explores what the media has framed as the "problem" and as the "solution," how the media has depicted substance-using pregnant women and in particular Ms. G., and how substance addiction issues are discussed. The analysis will also include discussion of who was cited in the media – whose voice gets to be heard – and whether there is a disjunction between who is "talked about" and who is "talked with" or cited. In addition, the analysis will examine whether key topics or issues of relevance to the Supreme Court decision were overlooked by the media's coverage; i.e., this chapter will explore what was missing from the press' discussion of the case.

Research Methods

In keeping with Callahan's discourse analysis, I undertook a thematic analysis of the Canadian print media's coverage of this Supreme Court case; the thematic analysis was similarly informed by critical discourse analysis (see Huber, 1998; Van Dijk, 1993). In addition to examining how the media covered the Supreme Court case and what its overall messages were, I sought to determine how the media reflects and reinforces dominant ideologies, as well as particular social biases, assumptions and attitudes – in this case, in relation to women who use substances during pregnancy.

My sample of print media articles was generated by searching 10 major Canadian newspapers for all articles relating to the Supreme Court decision, published between November 1 and November 15, 1997.[1] These 10 comprised the papers whose coverage was accessible to me via the

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[1] Although articles reporting on the case's lower court decisions were reviewed as background material, they were not included as part of the data for analysis. Similarly, although Canadian magazines such as *MacLean's* and *Chatelaine* had some coverage and commentary on this case, magazine articles were not included in my analysis.

Internet or microfiche.[2] Although I was not able to access all Canadian newspapers, the papers included in the sample represent a broad geographic distribution across Canada: *The Globe and Mail*, the *Victoria Times Colonist*, the *Vancouver Sun*, the *Calgary Herald*, the *Edmonton Journal*, the *Winnipeg Free Press*, the *Toronto Star*, the *Ottawa Citizen*, the *Montreal Gazette*, and the *Halifax Herald Chronicle*.

A total of 23 articles were found in the 10 newspapers. Of these, 10 were news stories, four were features (i.e., profiles of Ms. G. and her husband), eight were editorials/commentaries, and one was a letter to the editor. Separate analyses were undertaken of each category of article (news, features and editorial), and differences between categories will be discussed, where relevant. It also is important to note that although articles from 10 newspapers were analysed, because of the syndicated nature of Canadian newspapers, there was in fact considerable similarity or duplication of the print discourse. For example, six of the 10 new stories were adaptations or reproductions of Southam Press' coverage of the case; two news stories were based on the Canadian press' coverage. *The Globe and Mail*'s and the *Winnipeg Free Press*' news stories were, for the most part, original and unique.

I undertook the thematic analysis by reading the articles numerous times in order to become thoroughly familiar with the arguments and language contained in each. Then, Marilyn Callahan (who carried out the discourse analysis of the Supreme Court decision) and I collaboratively devised a set of questions that would frame our respective data analyses. For the media analysis, these questions were:

- What aspects of the Supreme Court decision are highlighted?
- How do the articles structure their arguments/discussion of the Supreme Court case?
- What is identified as the problem(s)?
- What is identified as the solution(s)?
- What, if anything, is said about Ms. G.? How is she depicted? How are pregnant substance-using women depicted in general?
- What, if anything, is said about substance addiction issues?
- What, if anything, is said about Aboriginal issues?
- Who gets to talk or claim authority? Who is cited?
- Whose voice is missing?
- What is missing from the media's coverage of the case?
- To what extent does the press cover issues that were not attended to in the Supreme Court decision?

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[2] No Francophone newspapers were examined as a part of this discourse analysis. This regrettable omission reflects the author's limited French-language skills and is not intended as a judgment regarding the relevance or importance of the Canadian Francophone press.

- Does the press present the Majority and Minority arguments as being in opposition to one another? To what extent does the media note their shared beliefs and assumptions?

I then reread and examined each article while considering these questions. I created a data base containing information on all questions, as well as each article's headline, lead sentence and noteworthy language/rhetoric, to enable quick reference, and comparison among articles. Preliminary findings were reviewed and discussed by Callahan and the other members of the project team; their feedback was incorporated into subsequent analyses.

Presentation and Analysis of the Data

What Aspects of the Supreme Court Decision are Highlighted?

One of the most fundamental ways of identifying and examining what was highlighted in the Supreme Court decision is to analyse the news stories' headlines and lead sentences. Clearly, the purpose of the headline and the lead sentence is to get at the crux of the story, and to do so in as pithy and "punchy" a fashion as possible. The headline and lead sentence should grab the reader's attention, provide core information and entice the reader to read on. The headline and lead sentence are thus extremely important in setting the stage for the rest of the article. Moreover, the headline and lead sentence generally contain a particular emotional tone – one that aims to influence the stance and sympathies of the reader. Thus, the opening passages of an article can frame the issues to be discussed and thereby shape our opinions and sentiments.

In this case, the headlines and lead sentences focused on the Supreme Court ruling as well as what the press determined were the key issues of the case. Selected headlines and key sentences were as follows:
Headlines:

> "Court puts mothers before fetuses; Supreme Court leaves rights of fetuses up to Parliament" (*The Globe and Mail*)
>
> "Unborn on their own, court says: Substance abusers can't be forced into treatment, ball in legislators' court" (*Winnipeg Free Press*)
>
> "Lawmakers must decide rights of the unborn, top court says; Judges overturn ruling ordering glue-sniffer into treatment program" (*Ottawa Citizen*)
>
> "High court won't recognize fetal rights; Split decision reached in case of pregnant glue-sniffer" (*Toronto Star*)

Lead sentences:

> "It's now up to politicians, not judges, to decide if unborn children should be protected from their abusive mothers" (Southam Press)

> "The Supreme Court of Canada has refused to recognize that a fetus is a person with legal rights, arguing that it's up to elected officials to make that decision" (Canadian Press)

What aspects of the Supreme Court decision are captured in these headlines and opening sentences? They tell us that:

a) the Supreme Court of Canada was asked to decide whether fetal rights exist independently from the rights of the pregnant woman;
b) the Supreme Court ruled that the court cannot grant fetal rights – only the legislature can do that; and
c) that because the court can't grant fetal rights, pregnant women can't be ordered to undergo mandatory (involuntary) treatment in the interests of fetal rights/protection.

A closer look at the language of the headlines and lead sentences reveals a particular conceptualization of the issues, however. For example, the headlines suggest that the case was, in essence, not only about whether a fetus had legal rights but about how those rights stacked up against those of a pregnant woman. The discourse in fact speaks of pitting fetal rights "against" women's rights – "Court puts mothers before fetuses" – in a zero-sum game fashion; i.e., the court's affirmation of women's rights meant that women were the winners while fetuses were the losers. Given this dichotomous framing, key messages that may be derived from the headlines and lead sentences include:

- that the fetus lost out in the Supreme Court decision;
- that the status of the fetus is in limbo; and
- that society's ability to "protect" the fetus is in jeopardy.

This dichotomous framing also suggests that the interests of a pregnant woman and her fetus can be separated; in addition, dichotomous framing predisposes readers to think that, since this is a legal case, they must necessarily "take sides."

Although the primary focus of these headlines and opening sentences is on fetuses[3] and their (putative) rights, given that this case ostensibly was about the balancing of women's rights with those of her "unborn child," and the case concerned a woman who sniffed solvents during her pregnancy, it is important to examine how women are depicted in the news articles' headlines and lead sentences. Interestingly, "women" as such do not appear in this discourse at all. Rather, the media has framed women as "mothers" ("Court puts mothers before fetuses"). This in itself is telling, in that it cues the reader to bring to mind prevailing ideologies about mothers and mothering, and about what makes for "good" and "bad" mothers (e.g., good mothers are "caring," "self-sacrificing," etc.). Of course, when "mothers" act in ways that are not in keeping with this ideology – when they are not self-sacrificing, for example, or when they do not put their children's or fetus' interests above their own – they can be deemed "bad" mothers, and indeed, "bad women," and castigated accordingly.

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[3] Despite most headlines being framed in terms of "fetal" rights, the language used in the lead sentences of these stories talks about the rights and protection of "unborn children." Arguably, the use of "unborn children" rather than "fetuses" prompts the reader to sympathize with the unborn and be unsympathetic with the mother (Keane, 1996; Beckett, 1995; Mitchell and Georges, 1997; Daniels, 1997).

Other ways in which women are discussed in the headlines and lead sentences are as "substance abusers" and "glue-sniffers." That the discourse is referring to *women* substance abusers and glue-sniffers is implicit, however, and can be discerned only through prior knowledge of the Supreme Court case. Through this kind of discourse, a particular facet of a woman's life – in this case, her substance use – has become all-important as a means of defining who she is as a person (a woman who sniffs solvents has thus become a "sniffer"). Arguably, this type of discourse is dangerous and dehumanizing, since it disconnects a particular dimension of a person from the context of his or her life. It also paves the way for society to devalue individuals or to "write them off" – in effect, to throw them away.

Finally, the discourse of Southam Press' lead sentence tells us that women (who use substances during pregnancy) are "abusive mothers." And because "abuse" generally connotes intentional behaviour, this discourse prompts readers to assume that such women abuse their child(ren) willfully. Indeed, the abuse has not been framed as "self-abuse" or even abuse of the substance itself – the abuse is directed toward the (unborn) child. This makes it all the more worthy of action/punishment. Furthermore, the discourse implies that the "mothers" themselves are to blame for the "abuse." There is no discussion of other people's or society's role in the women's substance use.

Another key theme stemming from the above is that "unborn children" need to be protected; moreover, they need to be protected, first and foremost, from their "abusive" mothers. Yet presumably, if politicians were to develop legislation in the interest of protecting "unborn children," the law should protect a fetus from abusive fathers, as well as community and environmental hazards, not just from abusive mothers. By singling out "abusive mothers"/women, this discourse reinforces prevailing ideologies that mothers/women are principally if not solely responsible for the safety and protection of children.

A strong message that follows from this is that measures should be imposed to "protect" the unborn child and that it is appropriate for legislation to enforce these measures. How should we protect "unborn children" from their mothers? In child welfare situations, "protection" of the child generally involves apprehension or removal from the abusive agent. Yet, when "mothers" and "unborn children" are inseparable, when they are inextricably physically connected, how can the fetus be protected from the mother? No answer to this question is explicitly stated, but the reader is left with the strong sense that "something needs to be done" – and presumably done *to* the mother – for the good of the fetus.

A fourth theme evident in the discourse of the headlines and lead sentences is that the Supreme Court judges have let the Canadian public down. Thus, "it's up to" politicians to take the necessary stand to ensure that "unborn children" are protected. Framing the lead sentence as "The Supreme Court of Canada has refused to recognize that a fetus is a person with legal rights" implies that the fetus does in fact have rights, but the Supreme Court is not honouring them. Implicitly, there is criticism of the court for "refusing the recognize" these rights.

In sum, by framing the key issues in this case in terms of the "unborn child's" rights and need for protection, the media discourse has shaped our thinking about who is innocent and who is to blame for the "problem." Since, as a society, we want and need to protect the innocent (unborn) children, the reader is prompted to seek recourse from the Supreme Court, which appears to be shirking its responsibility to grant fetal rights and therefore ensure the protection of children.

What if rather than stating that "the Supreme Court has refused to recognized that a fetus is a person," the sentence had been: "The Supreme Court has upheld its earlier judgments that a fetus is not legally a person until birth?" Here the Supreme Court is not seen as shirking its (moral, if not legal) responsibilities, but as demonstrating consistency and congruence with prior legal decisions. Or, what if the lead sentence had been: "The Supreme Court has upheld that women have fundamental rights to autonomy, privacy and liberty, and that these rights cannot be abrogated during a woman's pregnancy?" Finally, what if the stories' lead sentence focused on pregnant women's addiction issues, why women may become addicted, and the need for better resources for treatment? The difference in tone is obvious.

What Does the Media Report from the Majority and Minority Judgments?

Overall, the 10 news stories followed a fairly similar pattern, in terms of how the articles and arguments were structured. All articles began with a statement of the Supreme Court decision and a one-sentence description of Ms. G.'s case. This was followed by a presentation of the key arguments put forward by the Supreme Court Majority judgment, with quotes taken, presumably, from the decision. Following this, the articles varied somewhat: several provided a more in-depth discussion of Ms. G. and her case along with, in most cases, at least one direct quote from Ms. G.; other articles presented key arguments/quotes from the Minority opinion; and others provided commentary on the case from a number of sources, including Federal Justice Minister Anne McLellan, and interest groups such as the Alliance for Life and the Canadian Abortion Rights Action League. Regardless of the ordering of the stories' components, nearly all articles included some coverage of each of these topics, although the amount and depth of discussion varied.

In our analysis of the media's reporting of the Supreme Court case, we will focus first on the press' discussion of the Majority's arguments and then on the Minority's arguments. This will be followed by an examination of how Ms. G. was depicted in the newspapers' discourse.

Supreme Court Majority's Arguments

Following an attention-grabbing lead paragraph, all of the 10 news articles began by presenting the Majority opinion's key arguments – or at least those arguments deemed to be key by the press – accompanied by relevant quotes by Justice Beverly McLachlin. A compilation of these arguments across newspapers[4] is shown below (the numbers in parentheses refer to the code number for the newspaper making the point[5]):

- "The only law recognized is that of a born person. Any right or interest the fetus may have remains inchoate until the birth of the child." (1)
- Only law-makers can make a change of such "major impact and consequence" to existing legal principles about the status of the unborn. (1, 2, 3, 4, 5, 6, 9)
- To do otherwise "would place the courts at the heart of a web of thorny moral and social issues that are better dealt with by elected legislators. It is not every evil that attracts court action; some evils remain for the legislature to correct." (1, 3, 4, 5, 9, 10)
- "In short, these are not the sort of changes which common law courts can or should make." (7, 8)
- "Any intervention to further the fetus' interests will necessarily implicate – and possibly conflict with – the mother's interest" (1); "to make orders protecting fetuses would radically infringe on the fundamental liberties of pregnant women" (1, 3, 4, 5, 7, 8, 9); mandatory treatment would violate "the most sacred sphere of personal liberty – the right of every person to live and move in freedom." (1)
- "A pregnant woman and her unborn child are one." (1)
- "If anything is to be done, the legislature is in a much better position to weigh the competing interests and arrive at a solution that is principled and minimally intrusive to pregnant women." (1, 3, 5, 7, 8)
- Any attempt at legislation would have to comply with the Charter of Rights and Freedoms. (3, 4, 9)
- While there is no question that sniffing solvents can harm an unborn child, the impact of such things as smoking and occasional drinking is not as easily classified. (1, 3, 7, 8, 10)
- In addition, changing the law "to make a woman liable for life-style related fetal damage may be counter-productive." Pregnant women suffering from alcohol or substance abuse addictions may not seek prenatal care for fear of being confined or ordered to undergo mandatory treatment. (10); aggressive intervention might simply drive the problem underground (1, 3, 5); "in the end, orders made to protect the fetus' health could ultimately result in its destruction." (1, 3)
- This is not a story of heroes and villains. It is the more prosaic but all-too-common story of people struggling to do their best in the face of inadequate facilities and the ravages of addiction. (1, 3, 4, 5, 10)
- Solvent abuse cannot be described as a "lifestyle choice." (1)

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[4] Not all of these arguments appeared in all articles. In fact, in general, an article would contain only three or four of these arguments.

[5] Newspapers are numbered as follows: *The Globe and Mail* (1), the *Victoria Times Colonist* (2), the *Vancouver Sun* (3), the *Calgary Herald* (4), the *Edmonton Journal* (5), the *Winnipeg Free Press* (6), the *Toronto Star* (7), the *Ottawa Citizen* (8), the *Montreal Gazette* (9) and the *Halifax Herald Chronicle* (10).

- "This said, the legal question remains: assuming evidence that a mother is acting in a way that may harm her unborn child, does a judge, at the behest of the state, have the power to order the mother to be taken into custody for the purpose of rectifying her conduct?" (10)

The Majority's Framing of the "Problem" and the "Solution"

Based on the media's coverage of the arguments, it would appear that the Majority has framed "the problem" in terms of the struggle to balance the fetus' need for protection with women's legal rights to freedom and liberty. Thus, the "problem" as framed by the Majority might be: What is the role of the court in protecting the fetus from harm and, in particular, harm that results from maternal substance use, when the fetus isn't considered a person, with legal rights, until its birth?

As Callahan argued in Chapter 2, the arguments presented by the Supreme Court Majority – like those of the Respondent in this case – were essentially legal arguments made on the basis of legal principles and precedents. The Majority opinion's essential argument, both in the judgment and as covered by the press, was that there exists no precedence in law that could grant a fetus legal rights prior to its live birth. Thus, anything done to "further a fetus' interests" – in the name of fetal rights – would necessarily have a bearing on the "mother"; this is so because the "fetus and the pregnant woman are one."

The Supreme Court Majority does not dismiss the idea of fetal rights, however, nor the idea that it is not appropriate to address these issues through legislative means. Rather, it states that the granting of fetal rights must fall within the purview of Parliament or the legislature because of the magnitude in the change to law that this would represent. With this statement, the Majority has removed the Supreme Court from being involved in what is sure to be a thorny political debate, while at the same time seeming to be sympathetic to both "sides" of the case. Note, however, that regardless of whether it is the legislature or the courts that entrenches fetal rights, presumably any actions taken pursuant to those rights would still "implicate" women's interests and rights. The Majority's argument apparently appreciates this, since Justice McLachlin cautions that any legislative solutions will have to be in line with the Charter. One wonders how potential legislation, particularly that which would allow for mandatory confinement, could withstand a Charter challenge. The Majority's argument does not shed light on how any legal solution would adequately address this.

Indeed, the Majority's "solution" to the problems arising from this case is highly ambiguous. The media's discourse devotes considerable space to presenting the Majority's primary recommendation: "If anything is to be done," the elected legislature is the appropriate body to address the matter. And because this idea is repeated frequently in the Supreme Court decision, it might appear as though the Majority truly does favour legislative review and reform as a means of "correcting" this social "evil." However, because the Majority's "solution" regarding legislative change is always preceded by the conditional clause "if anything is to be done," it is unclear whether McLachlin's possible reservations about this course of action outweigh her support for it, as well as what those reservations may in fact be.

Nevertheless, if it were the case that the Majority were to endorse a legislative solution, then it becomes apparent that the Majority and the Minority share a fundamental belief: that it may be permissible and appropriate for the state to control a woman's behaviour in the interests of fetal "protection." Interestingly, any discussion of there being shared ideology between the two "sides" of the Supreme Court decision is entirely absent in the media discourse.

There appear to be other ambiguities and contradictions within the Majority's arguments as well. For example, although Justice McLachlin appears to be pushing for a review of current legislation or new legislation to address the issue, she simultaneously is cited as saying that mandatory treatment may be counter-productive. The media doesn't discuss how McLachlin reconciles the ideas that, on the one hand, legislation that may allow for mandatory treatment is appropriate and, on the other hand, that mandatory treatment may be counter-productive. Indeed, the evident contradiction in these arguments is invisible in the press' coverage.

The media provides only limited discussion, in three of the 10 news stories, of why mandatory treatment may be counter-productive. Although the discussion does note that mandatory treatment may drive substance-using pregnant women "underground," it plainly does not include substance-using women's own compelling testimony to this effect. This important discussion of why mandatory treatment is counter-productive is given relatively little attention in the media discourse, which is an important and telling oversight in the media coverage.

Another intriguing contradiction in the Majority's arguments, as related by press coverage, concerns its discussion of addiction issues. McLachlin at times appears to appreciate the complexity of addiction and treatment, as evidenced by her important statement: "This is not a story of heroes and villains. It is...a story of people struggling to do their best in the face of inadequate facilities and the ravages of addiction." At other times, however, McLachlin appears to revert back to discussing substance use in pregnancy as "lifestyle-related fetal damage."

The importance of McLachlin's statement must be underscored, since this could well contain the essence of a non-dichotomous framing of the "problem" (i.e., not framing the issues in a way that pits women against fetuses, or certain women against other women). Moreover, this was just about the only statement within the *entire* print media coverage of the case that made reference in any way to addiction issues. McLachlin's statement could also be connected with – and could thus strengthen – her other point that "a woman and her fetus are one." Interestingly, the media coverage failed to make this connection.

Unfortunately, the importance of McLachlin's statement seemed to have been largely overlooked by the media coverage: it was included in only five of the 10 news stories, and was noted in only one of the 10 editorials/commentaries. Why would the media tend to ignore the Majority's key statement? Perhaps it is so much simpler to paint a picture of villains and heroes. Perhaps McLachlin's comment sets us thinking about the complicated context around which the issues need to be framed, but such a context would be too much to digest, given the paucity of typical media accounts of the news. Perhaps the quote also veers away from solely blaming substance-using women for the "problem." Perhaps the quote raises issues about why existing facilities are inadequate, why there aren't enough of them, and why they may not be sufficiently geared to women's particular needs, let alone those of pregnant women. Perhaps an analysis of McLachlin's statement also subtly leads us to think about the role and responsibility of men, communities and society at large in contributing to our children's, and in particular, to our "unborn" children's health and well-being. In other words, perhaps we need to consider that the responsibility or duty to care for our children (born or not) may not rest solely with the (expectant) mother. Although we cannot know why the media essentially ignored the importance of this statement, and indeed omitted it altogether in half of the articles across the country, that the media made these omissions is notable and speaks to the way in which it has constructed the issues of the case and its efforts to "inform" public opinion about the issues.

Finally, note that media's coverage of the Majority's argument does not include any discussion of Ms. G. herself, of her Aboriginal ancestry, or of the experiences of substance-using women. This gives the impression that Ms. G.'s life story doesn't figure into the Majority's decision.

Supreme Court Minority's Arguments

Following a presentation of the Majority's position, seven of the 10 news articles presented the Supreme Court Minority's key arguments, and relevant quotes by Justice John Major. A compilation of these arguments, across newspapers, is shown below:

- "Someone must speak for those who cannot speak for themselves." (3, 5, 10)
- "When a woman chooses to carry a fetus to term, she must accept some of the responsibility for its well-being, and the state has an interest in trying to ensure the child's health." (1)
- "Society does not simply sit by and allow a mother to abuse her child after birth. How then should serious abuse be allowed to occur before the child is born?" (3, 5, 9, 10)
- It would be wrong for the state to "stand idly by" while a reckless mother inflicts serious, irreparable harm to a child she has decided to bring into the world. (3, 5, 9)
- The "born alive" rule has been superseded by medical advances. "The born alive rule is a legal anachronism and should be set aside, at least for the purpose of this appeal." (1)
- In order to safeguard a woman's rights, intervention in her pregnancy could be restricted to cases where it is reasonably probable that her behaviour would cause "serious, irreparable harm to the unborn child." (1, 7, 8)
- "In any event, this interference is always subject to the mother's right to end it by deciding to have an abortion." (1)
- Women should be forcibly confined when their behaviour causes serious irreparable harm to the fetus. Temporarily confining a mother as a last resort is a "fairly modest" imposition when balanced against the devastating harm that substance abuse will potentially inflict on her child. (5)
- "The afflicted children may be sentenced to a permanently lower standard of life. To advocate not confining the mother to prevent this harm seems extreme and short-sighted." (5)

The Minority's Framing of the "Problem" and the "Solution"

How does the Minority frame the "problem"? Based on the media's coverage, it seems that the Minority has framed the problem in terms of the harmful behaviour of "reckless" pregnant women, and the subsequent, lifelong "damage" to "unborn children"; the Minority's problem is to ensure that the fetus' health and interests are protected "against" women's recklessness. The Minority's solution is in the granting of fetal rights, which then makes way for the curtailment of women's rights under specific circumstances, and for certain women to be forcibly confined in the interests of fetal protection. As will be shown, the media's presentation of the Minority's arguments essentially mirrors the Appellant's arguments in the Supreme Court decision, as discussed by Marilyn Callahan in Chapter 2. The media encapsulated the Minority's core arguments, although the press' discussion was highly abbreviated.

In contrast with the Supreme Court Majority's position, the Minority's argument is essentially a moral one; that is, when the Minority states that "it would be wrong for the state to stand idly by" it is arguing that it would be morally wrong, not legally wrong. The Minority pleads for the court to act, to alter existing law, in order to "protect" the fetus from "abuse" and to help ensure fetal health. Legally, the Minority appeals to advances in perinatal medicine and medical imaging/technology to support its argument to grant fetal rights, and by granting fetal rights, to sanction mandatory intervention with pregnant women whose behaviours compromise fetal rights.

Embedded in nearly all the Minority's arguments, as presented by the media, are a number of critical – and arguably erroneous – assumptions. These will be briefly discussed in turn.

"When a woman chooses to carry a fetus to term, she must accept some of the responsibility for its well-being, and the state has an interest in trying to ensure the child's health." This assertion assumes that any fetus carried to term is done so by the woman's choice. Along with this, it assumes that all women are equal in that they have equal access to birth control and abortion, and thus can equally "choose" to carry the fetus to term, or not. By framing the argument in terms of women's "choice," the statement reveals a very poor appreciation of the realities of women's lives in terms of reproductive health. In addition, in speaking only about a woman's responsibility for the well-being of her fetus, the statement obscures who else may be morally and legally responsible for the fetus'/child's well-being. Missing is any discussion about the role and duty of men, communities, the private sector and the state in promoting and ensuring children's health.

"Society does not simply sit by and allow a mother to abuse her child after birth. How then should serious abuse be allowed to occur before the child is born?" (3, 5, 9, 10) It would be wrong for the state to "stand idly by" while a reckless mother inflicts serious, irreparable harm to a child she has decided to bring into the world. (3, 5, 9) These arguments are quite similar to the preceding one; however, there are several additional assumptions in these two statements. First, "abuse" here refers to the use of substances by pregnant women, and the impact that substance use has on a fetus. The assertion assumes that we know with certainty that a woman's substance use ultimately results in serious, irreparable harm to her child. In fact, although there is strong scientific evidence that excessive maternal alcohol use can result in FAS and other alcohol-related disabilities, the evidence remains equivocal regarding the long-term effects of other substances on the fetus/child.

Moreover, the term "abuse" presumes intentionality; i.e., that a woman is willfully inflicting harm to her fetus/child. This assumption needs to be held up and challenged, and is in fact erroneous in light of the voiced experiences of substance-using women.

Like the preceding argument, by focusing solely on women's behaviours, this statement also renders invisible any harm to a fetus that may result from other "abusive" agents, including physical assault by men, environmental toxins and other factors. In addition, the arguments imply that "society's" or the "state's" only legitimate response to pregnant women who use substances is punitive or coercive action. Clearly, other possible responses, such as an overhaul of state-funded treatment/addiction resources – in particular, those geared to (pregnant) women – would ensure that the state was not "standing idly by"; however, it is equally clear that this is not the type of response recommended by the Minority's arguments.

Finally, embedded in these arguments is the notion that a fetus has the same "rights" to protection as a child, although the assertions also suggest that these "rights" apply only to a fetus whose mother has "chosen to bring it into the world." In other words, implicit in these arguments is that some fetuses have legal rights while others do not.

In order to safeguard a woman's rights, intervention in her pregnancy could be restricted to cases where it is reasonably probable that her behaviour would cause "serious, irreparable harm to the unborn child." (1, 7, 8) As above, this argument assumes that "we" (i.e., medical science) can accurately predict when substance use will cause "serious, irreparable" harm to a developing fetus. At this time, this is simply not the case.

"In any event, this interference is always subject to the mother's right to end it by deciding to have an abortion." As above, this argument assumes that all women have equal access to abortion; i.e., that it is equally available and a viable "choice" for all women. This argument mistakenly equates abortion's legality with its being culturally acceptable and economically and geographically accessible to all women. This argument is also blind to very real power differences between a woman and her partner, who may not "consent" to her abortion, and to the resulting lack of choice that she has in such a circumstance.

Women should be forcibly confined when their behaviour causes serious irreparable harm to the fetus. "To advocate not confining the mother to prevent this harm seems extreme and short-sighted." (5) As above, these assertions assume that mandatory treatment or confinement is the state's only appropriate means of preventing women's substance use during pregnancy. Embedded in this is the additional assumption that mandatory confinement will completely eliminate women's substance use and that there is no access to substances in places of confinement. Ironically, women's own testimony – as well as a substantial body of literature – tell us that this is certainly not the case.

In sum, although the Supreme Court Minority's position received less discussion in the press than the Majority judgment, the coverage and accompanying quotes were extremely potent in view of their emotionally charged tone and language. Regardless of whether one is in agreement with him or not, Justice Major's moralizing, his condemnation of pregnant substance-using women and his advocacy for "those who cannot speak for themselves" ("unborn children") make for far more powerful (and possibly compelling) reading than does the Majority's relatively dry, legalistic arguments. The press, in its news articles, does not provide any commentary on either the Minority's or the Majority's arguments, presumably in the interests of "impartial" reporting. In light of this, it is interesting and quite telling that several of the Minority's arguments are largely echoed in the news articles' headlines and lead sentences, and the articles' stance in depicting Ms. G. is very much in keeping with Justice Major's views. It seems that the media discourse has constructed this story in ways that reinforce dominant ideologies and which will no doubt shape public opinion and policy debate.

Finally, it is important to note that the Majority's and Minority's framing of the problem, at least as presented by the print media, did not substantially differ from one another. In essence, both "sides" framed the problem in terms of how to protect the fetus from harm, in particular, harm caused by its mother's substance use. This is in contrast to framing the problem in terms of, for example, the need to identify and address the underlying causes of women's substance use and addiction, and/or in terms of identifying and addressing the healing/health needs of pregnant women who use substances. (Note that implicit in these alternative conceptualizations is the idea that by attending to the healing/health needs of women, fetuses will be protected.) In addition, in identifying "solutions" to the "problem," the Majority and Minority were in agreement about at least one: that a legal route (i.e., by reviewing and possibly reforming legislation in order to protect a fetus from harm) may be (most) appropriate. These key shared beliefs of the Majority and Minority were largely overlooked by the media's coverage of the case.

Editorials' and Commentaries' Framing of the "Problem" and the "Solution"

In addition to analysing the news reports on this case, it is important to examine Canadian newspaper editorials'/commentaries' framing of the issues because, by definition, it is in these articles that the print media's views will be most plainly stated.[6] Overall, Canadian editorials' framing of the "problem" paralleled that of the news stories (see previous discussion of the Majority's and Minority's framing of the problem): How can a fetus be protected from harm, especially harm caused by its mother's behaviour/substance use? For example, two articles framed the problem as follows:

> The question now is whether (fetal) rights can be extended to include protection from harm or whether there are better ways to protect a fetus in cases such as this one....
>
> Question: Does the state have the right to force a pregnant woman to receive medical treatment to protect her unborn child?

In describing the Supreme Court case, several editorials also highlighted Ms. G.'s thwarting of the support offered to her by Winnipeg Child and Family Services; the discourse in most articles emphasized the beneficence of the variety of "helpers" who attempted to assist Ms. G., including the

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[6] An important reminder here relates to the syndicated nature of Canadian newspapers. That is, at least five of the 10 Canadian newspapers examined are published by Southam Press; as a result, the same article by Andrew Coyne was reprinted as these newspapers' commentary on Ms. G.'s case. Coyne's article was extremely critical of the Supreme Court decision and used highly negative and vitriolic language in its condemnation of pregnant substance-using women. Two of the five newspapers carrying Coyne's piece included a counter-commentary (by the *Edmonton Journal*); in these papers, the two clearly opposing articles ran side by side, enabling readers to examine multiple perspectives on the issue. In the three other newspapers, however, Coyne's article was the only commentary provided, which arguably sends the message that Coyne's position was endorsed by the newspapers' editorial staff.

Manitoba trial judge who forced Ms. G. into treatment. Ms. G., by contrast, was nearly always depicted far less sympathetically:

> In August, 1996, five months into her latest pregnancy, the Winnipeg C&FS went to court, seeking to place her into the *protective custody* of a substance-abuse centre, *for the good of her unborn child.* The trial judge, *grasping at legal straws*, issued the order... [emphasis added].
>
> The case began when Winnipeg social services – *with what [one] must assume were the best of intentions, born of legitimate frustrations* – asked the courts to order the woman, known only as Ms. G., into addiction treatment in the summer of 1996. Five months' pregnant with her fourth child, Ms. G. was, by all accounts, in dire shape thanks to long term glue-sniffing. Two of her three other children, all of whom had been taken into the care of social services, had been born disabled as a result of the addiction [emphasis added].

Only one editorial presented a different framing of the problem, and similarly, a less damning portrait of Ms. G.:

> McLachlin stresses the far-reaching impact of any granting fetal rights, even in extreme cases like the glue-sniffing Winnipeg woman whose case prompted the decision.... As McLachlin says in her ruling, this case is not one of heroes and villains. No one can be immune to the tragedy of young women, like the Winnipeg woman, ingesting substances that can leave their unborn child brain damaged....

Interestingly, this was the only editorial/commentary that picked up on McLachlin's important "heroes and villains" quote. This was also the only article that described the entire situation as tragic, not just the impact of substance use upon fetuses. The editorial suggested that the situation is tragic because it is a waste of human potential, a loss of a woman's potential as well as that of her unborn child. The tragedy is seen to involve a woman's pain and suffering – not simply "damage" done to her fetus. In this editorial, there is the suggestion of sympathy for the woman, and the sense that whatever harm may befall her fetus was not willfully inflicted on her part.

Editorials were divided in their opinion about the Supreme Court decision, and in their framing of the "solution." Some articles came out clearly in support of the Supreme Court's judgment:

> The court was acting properly within its jurisdiction, and acting appropriately, interpreting, not making, the laws of the land.

Others were critical of the decision, and one commentary – reprinted in five of the 10 papers – used highly acerbic sarcasm to express its outrage and disgust about the verdict:

> *A pregnant woman, a habitual glue-sniffer, is slowly poisoning her unborn child. It was within the court's power to restrain her from such harmful behaviour*. But wait! Parliament has passed no law conferring upon the fetus the status of a person. No

> person, no rights.... After all, as the majority wrote, this would entail a delicate weighing of competing rights and interests. *Let's see: on the one hand, the mother would endure a few weeks forced abstention of her preferred solvent. On the other hand, the child would be spared a lifetime as a vegetable. You can see the conundrum....* A moral portrait of the late 20th century: an age when the law could be used to protect us from ourselves, but not to protect children from their mothers; when it was illegal to ride a bike without a helmet, but a sacred liberty to bear a child with fetal alcohol syndrome [emphasis added].

Despite their differences in opinion regarding the outcome of the case, nearly all editorials seemed to share what emerged as also the common ground between the Majority and Minority reports in terms of a "solution" to the issues: that a review and possibly reform of legislation in order to protect a fetus is indicated. As these articles concluded:

> We say "the law is it now stands" because laws, both provincial and federal, can be changed. In this case, the law should be.... While respecting a pregnant woman's right to autonomy, Canadian law must also recognize that a woman who has indicated she intends to carry a fetus to term has a duty to care for that potential life.
>
> The moral and religious quagmire of abortion notwithstanding, the question of fetal rights is fraught with controversy. Still, thinking Canadians want to explore ways of better weighing individual rights with common sense approaches that better handle obvious threats to well-being. This is the third time that the Supreme Court has tossed to Parliament the question of fetal rights. It's time elected officials swallowed hard and took up the cause.
>
> The Supreme Court's ruling in the fetal rights case involving a Winnipeg woman sent the controversial issue right back where it belongs – to the politicians.... It is an issue that has outpaced the law governing it, and a review is clearly needed.... There is a danger that this clear and urgent need will go unaddressed because legislators fear reigniting the abortion debate.

Interestingly, revealed in the first quote are many of the same assumptions evident in the Minority's arguments: that all women are equal, that all women have equal access to abortion and can equally "choose" to carry a fetus to term or not, that mandatory confinement will completely prevent women from using substances (i.e., that there is no access to substances in places of confinement), that some fetuses have legal rights while others do not, and that "we" (medical science) can accurately predict when substance use will cause "serious, irreparable" harm to a developing fetus. This begs many questions, including: How and when would a woman need to indicate her intention to carry the fetus to term? What would this look like? What if she changed her mind? How would this be "enforced"? What does her "duty to care" involve? Is it simply *her* duty to care, or do others, including society, have such a duty? How can a woman's/mother's personal duty and social duty be differentiated? Unfortunately, this article is completely silent on these issues.

The second quote is of interest because, although it was ultimately supportive of the Majority's decision and was critical of Justice Major's desire to curtail behaviour that causes "serious irreparable harm" because of the vagueness of that phrase, it also suggested that Major's remedies "may be on the right track." What is meant by "common sense approaches that better handle obvious threats to well-being" is far from clear. However, mandatory treatment/confinement may well be among the approaches envisioned. In the end, the "solution" advocated by this editorial appears to be a public debate on these issues, with legislators taking leadership. Although not expressly said, it seems that the debate would focus on reviewing legislation to allow for mandatory confinement. Other types of approaches, especially those that try to integrate the healing needs of the woman with the health needs of the fetus, are not alluded to at all.

Only one editorial put forward a "solution" that was substantially different from legislative review: this article lobbied for channeling resources into having effective voluntary addictions treatment and argued that extreme cases, such as that of Ms. G., do not justify the reform or creation of legislation:

> While the granting of fetal rights might begin only in restricted circumstances, the pressure to extend them to other situations would be inevitable.... Far better to concentrate government efforts on having effective voluntary programs for drug treatment and prenatal care.... In such a voluntary system there will always be a few tragic cases who refuse help, but those cases do not justify the incarceration of pregnant women.

This editorial was also the only one to provide a thorough discussion of the dangerous implications and potentially negative, counter-productive consequences of mandatory treatment/confinement. It included points such as: mandatory treatment could erode women's rights; the law would have to be draconian with limited appeals permitted, if any; the law would inevitably be applied differentially and unfairly (i.e., to poor, non-white women); the law would drive the problem underground – women would avoid prenatal care; and the law might prompt women to seek abortions. Moreover, this was the same editorial that framed the "problem" as a tragedy for young women and did not adopt a shaming and blaming stance in relation to Ms. G.

This particular editorial was published in the *Edmonton Journal* and reprinted in one other newspaper. In these two newspapers, it ran alongside Andrew Coyne's inflammatory commentary that belittled the Supreme Court's decision and showed no sympathy whatsoever to "habitual glue-sniffers" who "poison their unborn children." However, Coyne's commentary stood alone in three other newspapers. Thus, the *Edmonton Journal*'s piece appeared in two Canadian newspapers; Coyne's piece was published in five. This disparity alone sends a strong and arguably worrisome message about the ideologies of the Canadian print media.

How is Ms. G. Depicted in the Print Media?

Analysing how the press portrayed Ms. G. is important because it so closely relates to how the print media has framed the issue of substance use by pregnant women. Clearly, Ms. G. is the focus of the

Supreme Court case; her story could – and arguably should – be the centrepiece of the media's coverage.

Yet, how complete a description do we have of Ms. G.? What does the media tell us about her background, her heritage and culture, the conditions in which she grew up and lived as an adolescent (when her solvent addiction began), the precipitating factors leading to her solvent use, her family life, her social support network, her attempts at treatment, recovery and healing, her feelings about motherhood, her struggles living in poverty, her views on what appropriate and useful treatment would be, and her aspirations? What does the media coverage choose to reveal and how? In shaping our picture of Ms. G., what kind of language does the media use and what messages or connotations does this language leave with the reader? And, just as important, what is missing from the print media's coverage of Ms. G.?

In addition, in analysing the media's portrayal of Ms. G., it is important to examine the media's depiction in relation to the Supreme Court's description: to what extent did the media's coverage mirror what was presented in the Appellant's and Respondent's factums and in the Majority and Minority opinions? Although these documents presumably constitute a readily available body of information about Ms. G., the nature and comprehensiveness of this information may be in doubt. For example, Callahan argues that the Appellant's highly unsympathetic depiction of Ms. G. – which focused on her solvent addiction, her poor parenting history and her rejection of professionals' efforts to assist her – was one of the only places in which Ms. G.'s life story was presented. These negative and blameworthy aspects of Ms. G.'s life were put forward and highlighted in order to bolster the Appellant's legal case that fetal rights should be granted and, consequently, Ms. G. (and others like her) should be forced to undergo treatment or confinement in the interests of fetal protection. The Supreme Court Minority opinion essentially reproduced the Appellant's depiction of Ms. G. and, if anything, emphasized aspects of her story that would heighten her culpability (e.g., the degree to which her children were permanently handicapped as a result of her substance use). By contrast, Callahan shows that the Respondent's factum and the Majority's judgment did not include substantial discussion of Ms. G.'s life story because this was not germane to their legal case. As a result, a more extensive and sympathetic portrayal of Ms. G. is altogether absent in the Supreme Court documents.

Overall, my analysis of the media discourse indicates that the press' depiction of Ms. G. seemed to parallel if not mirror the Appellant's and Minority's portrayal. As will be shown, the same type of themes (her addiction, bad parenting and rejection of services) figured prominently in the media's discussion, and few statements were offered to counterbalance the negativity of these themes. Although interviews with Ms. G. could have uncovered considerable information to contextualize the Supreme Court's unflattering descriptions of her (since the media was not constrained by the need to present only the information that would best "win" the legal case), there is little in the discourse to suggest that the media had any real interest in pursuing this. Instead, the media, like the Supreme Court, chose to leave many important gaps in our knowledge about Ms. G.'s life circumstances unfilled and at the same time highlighted those aspects of Ms. G.'s life that would, most likely, put public sentiment against her.

News and Editorial Articles' Depiction of Ms. G.

Although there were some descriptive references to Ms. G. (e.g., "a pregnant Winnipeg woman addicted to glue sniffing" and "a 22 year old pregnant woman who was addicted to sniffing glue"), the media most often used highly charged, evocative and negative language as part of the picture it painted of Ms. G.[7] Through a discourse analysis of the print media's depiction of Ms. G., the following themes were identified:

- Ms. G. as a sniffer/addict;
- Ms. G. as a bad mother;
- Ms. G. as uncaring and disinterested;
- Ms. G. as reckless, selfish and irresponsible ;
- Ms. G. as abusive;
- Ms. G. as uncooperative and ungrateful toward the state and social workers; and
- Ms. G. as sub-human: freakish and brain-damaged.

Ms. G. as a Sniffer/Addict

Although the headlines of most news articles and editorials were framed in terms of rights, in the headlines in which Ms. G. was specifically referenced, she was identified as "a (pregnant) glue-sniffer": "judges overturn ruling ordering glue-sniffer into treatment program," "split decision reached in case of pregnant glue-sniffer" and "sniffing mother came out of fog, took back her life."

Referring to Ms. G. as a "glue-sniffer" dehumanizes her and renders invisible her other dimensions and characteristics. She is no longer a person, a woman or even a pregnant woman. All she is for the reader is a "sniffer." By contrast, had the headlines replaced "glue-sniffer" with "Ms. G.," readers would have been more aware the story of a young woman who, we would learn, sniffed solvents during her pregnancy. Clearly, it is far more likely that readers' sympathies would go out to a person known as Ms. G. than to a "sniffer"; "sniffers," by contrast, warrant only scorn and blame.

The media discourse also speaks of Ms. G. as a "sniff addict": "The contentious case involved a 23 year old pregnant sniff addict from Winnipeg..." and "The case arose when C&FS in Winnipeg went to court to force a pregnant sniff addict into a treatment program to prevent her from further injuring her fetus."

Like "sniffer," being described as an "addict" is dehumanizing and depersonalizing in that being an "addict" has come to define who and what you are as a person. Moreover, there seem to be hierarchies within addictions in terms of public attitudes and stigma, with solvents generally being viewed as the most stigmatizing. It is no coincidence that solvents are also the substance generally associated with the most impoverished, isolated and marginalized people, predominantly Aboriginal people. Although addictions to cigarettes, gambling, food and alcohol can be as powerful and destructive, it is rare that people who are addicted to these substances are known as "addicts." Why do we never talk about a person as a cigarette "addict?" Because we don't stigmatize cigarette smokers in that way; the addiction is recognized as a socio-medical problem. This point relates to dominant ideologies that have cast substances as "good" and "bad" drugs, and have stigmatized and penalized substance users accordingly.

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[7] It could be questioned whether the use of the word "addicted" is purely descriptive because it raises the question of what meaning and connotation the term "addiction" has.

Ms. G. as a Bad Mother

Beyond referring to and defining Ms. G. as an "addict," a primary theme emerging from the discourse about her was that she was a "bad" mother. In fact, Ms. G.'s addiction is inextricably and causally linked to the press' depiction of her as a deviant and deficient mother; the media's discourse both reflects and reinforces society's dominant ideology that mothers who use substances are bad parents. What are other attributes of "bad mothers?" Who are they and what have they done to warrant such a label? The literature on the social construction of bad mothers tells us that they are, among other things, uncaring, selfish and not self-sacrificing, negligent and abusive (Swift, 1995). The media's depiction of Ms. G. emphasizes that she was all of these; indeed, important sub-themes of Ms. G. as a bad mother include Ms. G. as uncaring and disinterested, Ms. G. as reckless, selfish and irresponsible, and Ms. G. as abusive.

Ms. G. as Uncaring and Disinterested

In describing Ms. G.'s history as a mother, the newspaper articles refer to Ms. G.'s parenting competency as follows:

> The contentious case involved a 23 year old pregnant sniff addict from Winnipeg...who had already surrendered three children to the state.
>
> She had already given birth to three children, all of whom were eventually apprehended by the province's social workers.

Although the language of "surrendering" children may have specific legal meaning within child welfare legislation, the term strongly connotes a parent's lack of interest in assuming the responsibilities of parenting. It also connotes agency and intentionality: Ms. G., it would appear, did not care about her children; thus, she *chose* to surrender them to the state. The other comment by the press regarding Ms. G.'s parenting history notes that her other children were all "eventually apprehended" by the state. This way of framing the story arguably focuses more on Ms. G.'s lack of competence as a mother than on her lack of interest. Nevertheless, the message conveyed is that Ms. G. was not an adequate parent. In its accounts of Ms. G.'s parenting, the media says nothing about whether Ms. G. had sufficient social, health and economic resources to parent her children safely and adequately, nor did the media present her own account of her parenting history or her perspective on the reasons for her children's apprehension by the state.

Ms. G. as Reckless, Selfish and Irresponsible

Another major theme in the media's discourse about Ms. G., contributing to her being depicted as a bad mother, was that she was highly selfish and "reckless." Her "recklessness" and "irresponsible behaviour" was a strongly noted in the Supreme Court's Minority opinion: "a reckless mother inflicts serious and irreparable harm to a child she has decided to bring into the world" (Major). Note that this message was never challenged or questioned in the media discourse, and indeed, the message is implicitly reproduced, in tone if not in content, in many of the press' headlines and lead paragraphs.

Similarly, Ms. G.'s "selfishness" was a strong theme evident in a number of the media's editorials/commentaries on the case:

> ...a pregnant, glue-sniffing Winnipeg woman, identified only as Ms. G., could not be forced to enter a treatment program to protect the health of her unborn child.
>
> Let's see: one the one hand, the mother would endure a few weeks' forced abstention from her preferred solvent. On the other, her child would be spared a lifetime as a vegetable.

In these examples of press coverage, Ms. G. is depicted as not being willing to forego her own desires or needs for substance-induced gratification for the sake of her fetus – even for the short term. Ms. G.'s refusal to subordinate her own "needs" clearly runs counter to society's image of a "good" mother, where self-sacrifice is a hallmark and defining virtue. In a similar vein, another editorial alludes to Ms. G.'s social irresponsibility and possible selfishness in becoming pregnant for the fourth time at the age of 22: "Yet here she was again, at 22, getting ready to bring her fourth child into the world."

An implicit message here is that Ms. G. – a young, poor, presumably welfare-receiving, substance-addicted Aboriginal woman – should not be having children, especially given that the "burden" of caring for these children will, most likely, fall to the state.

Ms. G. as Negligent and Abusive to her Fetus

The preceding point is essentially echoed in the discourse related to the sub-theme of Ms. G. as negligent and abusive:

> She already had three children, two of whom had suffered permanent harm in the womb from her addiction and are wards of the state.
>
> Two of them are mentally and physically disabled, victims of fetal alcohol syndrome.

Here, however, the media stresses the "suffering" that Ms. G.'s children have presumably experienced as a result of her substance use; they are the innocent "victims" of her behaviour. Implicitly, she becomes blameworthy and villainous, all the more so because she "chose" to bring her pregnancy to term, she presumably knew of the likely ill effects that her substance use would cause to her fetus, she refused to enter treatment, and she "chose" to continue to use solvents during pregnancy. Ms. G.'s abusiveness and her culpability is underscored by yet another highly evocative statement by the press: "A pregnant woman, a habitual glue-sniffer, is slowly poisoning her unborn child."

This statement leaves no room for sympathy or compassion for Ms. G. There is no room for a reader to question whether Ms. G. herself ought to be viewed as a "victim" along with her children, whether Ms. G.'s "abuse" might not be better viewed as self-abuse, or whether she has had cause for suffering. Moreover, throughout all this, Ms. G.'s own accounts of her substance use and the reasons behind it, and of her feelings for her children and her history as a mother, are altogether invisible in the media discourse.

Ms. G. as Uncooperative and Ungrateful Toward the State and Social Workers

Another theme that emerged from the media's depiction of Ms. G. was her rejection – indeed, her thwarting – of professionals' efforts to help her address her addiction problem. This theme is captured well by the following: "Social workers have been consistently rebuked in their efforts to obtain treatment for her. She did try to get help once, but it was unavailable."

Here, the discourse emphasizes practitioners' ongoing work to connect Ms. G. with services; however, Ms. G. stubbornly and selfishly refused to enter treatment. The reader is again left with the sense that Ms. G. simply did not care about either her own healing, or perhaps more importantly, the health of her fetus. By contrast, social workers are depicted as trying to do everything possible to help Ms. G., despite her being a difficult client (or so it is suggested). Although the media discourse goes on to add that Ms. G. did once seek treatment (and was unsuccessful in accessing it because it was not available), this sentence seems almost to be a footnote to the first; the language is not nearly as powerful.

In fact, these two statements, taken together, should give rise to a number of critical questions: Why did Ms. G. refuse the treatment resources offered to her? What had been her previous experience with treatment – what, if anything, had she found effective and why? From her perspective, what were the barriers to effective treatment? Why was the help Ms. G. sought not available? What implications does this have for service planning, resource allocation and policy development? The media are silent on these matters – the questions are neither raised nor did the press choose to address them. Instead, the media reported on only selected and skewed "facts" within Ms. G.'s "treatment history" and have done so in a way that further denigrates her.

Ms. G. as Sub-Human: Freakish and Brain-Damaged

A final theme that emerged from the print media's depiction of Ms. G. was of her deficiency and sub-normality as a person, not just as a mother:

> She wore purple sweats and a faded tank top. There were scabs and bruises on her knees and elbows. Her eyes were glassy and her speech jumbled. She looked like a freak compared to the neatly dressed lawyers, social workers and reporters in the gallery.
>
> If a woman with a history of chronic substance abuse, who has already given birth to three children, two very nearly as brain-damaged as she....

Ms. G. is said to be "brain-damaged" and to "look like a freak." Moreover, she is portrayed essentially as the stereotypical "falling-down drunken Indian," in ways that evoke scorn and derision rather than sympathy and understanding. By describing her as a "freak," the discourse effectively distances Ms. G. from the middle-class, non-Aboriginal majority. In addition, implicit in the assertion that Ms. G. was "brain-damaged" is the suggestion that her substance use caused her mental disability. As long as this is the case, it is implied, there is little reason to be sympathetic to Ms. G.'s plight, since she effectively brought it on herself.

Ms. G.'s Own Perspective as Presented by the Media

In examining the media's depiction of Ms. G., it is important to note the disparity between the number of articles that talked *about* Ms. G. (all of them), and the number that talked *with* her and included quotes *by* her (approximately half). Even among articles that quoted Ms. G., there was a variance in what news articles tended to include. In the discussion that follows, the media's presentation of Ms. G.'s own perspective on the case and its underlying issues, as reflected by quotes by her, will be analysed. Attention will focus on disparities between different news stories, significant discrepancies between how the media elected to portray and talk about Ms. G., and how she is presented in the press, based on her own words.

The quote by Ms. G. that appears most frequently in the news articles (in five of the six articles that directly quoted her) was " 'I'm just happy it's over, I want to be out of the public' the soft-spoken woman said from her lawyer's office." Another quote that sometimes accompanied the above (in two of the five news articles and in one of the four features articles) was "The mothers that are pregnant out there that are addicted, they should give their babies a chance to live, like their mothers gave them a chance to live."

This quote is important, as it suggests that Ms. G. herself recognizes and is sympathetic to the notion of "fetal rights," and that she is to some degree supportive of taking measures (perhaps intervention) to ensure fetal health. In fact, in one news story, this quote was used in support of the article's claim that "Ms. G.'s sympathies are with the unborn." But is this a fair claim? It is misleading and unfortunate, because it gets us back to a dichotomous framing of the issue; i.e., that a person couldn't simultaneously sympathize with *both* the "unborn" and with substance-using pregnant women. We don't know that Ms. G. identifies with substance-using women, yet the media presents this quote in a way to suggest that she "sides" with the fetus.

The media's shaping of our thinking about Ms. G. and her sympathies is all the more apparent when we see how what was probably the most important of Ms. G.'s comments was so frequently cut from the media's coverage. After stating that the "mothers out there should give their babies a chance to live," Ms. G. is quoted in one article as saying, "I wish there was some way that you could help the unborn without forcing women into treatment.... Forcing women into treatment is far different than providing them with treatment." This quote is absolutely critical, as it enhances our understanding of Ms. G.'s views and experiences. It shows her attempt to grapple with the difficult issues involved, to find a "common ground" solution that would help support women and, at the same time, help ensure fetal health. It reflects Ms. G.'s attempt to *not* pit women against fetuses. And it reflects her appreciation, borne out of her own experience, that mandatory intervention is not an adequate "solution" to the problem.

The above quote was included in only *one* of the 10 news articles, and in one of the four features articles (and in none of the nine editorials/commentaries). The same feature article also included another important quote by Ms. G., one that was completely overlooked by the news coverage: "I'm happy I stayed [in the treatment program], because I made up my mind to stay. I wanted to mother my own baby." This quote suggests that what is critical is having hope and seeing an alternative way of life – being able to keep her child and not having it removed by the state. Ms. G. quit the treatment program because she could see and wanted another kind of life for herself. Mandatory treatment by itself would not have necessarily led to Ms. G.'s decision to try to end her addiction.

Overall, then, we see that the media, when it did provide Ms. G. with voice at all, tended to highlight her relief to be out of the public eye. The media also depicted Ms. G. as "sympathizing" with "the unborn" – and, by implication, castigating women with substance-use problems. Only in rare instances did the media show that Ms. G. was struggling to work through the issues and find a way to help women heal without doing so against their will. And only in the rarest of news stories did Ms. G. appear to readers as a caring and responsible woman and mother who wanted to take action to address her own addiction issues for the good of herself and her baby.

What is Said in the Media About Substance Addiction Issues?

What is most striking about the media's discussion of addiction issues is not so much what was said but what was not. In the coverage of Ms. G.'s case, there was extremely little discussion of addiction, including, most fundamentally, how to conceptualize this problem. This implies that there is no need for additional public awareness and debate about addiction issues, when arguably they are central to this Supreme Court case and are among the most important issues facing communities and society today.

Ms. G. was described by the press as an "addict." She was also said to be addicted to sniffing solvents. What does this really mean? As noted above, these terms are primarily a means to stereotype and stigmatize her.

One of the only other statements pertaining to addiction in the media discourse of Ms. G.'s case was the following quote from the Majority judgment: "This is not a story of heroes and villains. It is...a story of people struggling to do their best in the face of inadequate facilities and the ravages of addiction."

This statement is important because it reflects an appreciation of the complexity of addiction and treatment issues. At the same time, the media does nothing to expand on this statement. What *are* the ravages of addiction, for example, and what does it mean to people, and to addicts in particular, to be addicted? Moreover, as noted above, only one of the nine editorials/commentaries on the Supreme Court judgment discussed this statement. In the rest of the editorials/commentaries, it was ignored.

Finally, the Majority judgment asserted that solvent abuse cannot be described as a lifestyle choice. Although this comment follows logically from the preceding quote, it is important in that it reflects the tensions evident between the Supreme Court Majority and Minority positions. Thus, this statement by the Majority seems aimed to counter-balance claims that substance abuse is indeed a "lifestyle choice." These claims are implicit in the Minority's assertions about the need to constrain the behaviours of certain "reckless" women (i.e., Ms. G. and others like her who have "chosen" this lifestyle), which in turn suggests a framing of addiction as a moral failure.

What is Not Discussed in the Media's Coverage?

Among the issues and questions not tackled anywhere in the media's discussion of the Ms. G. case are:

- Why did Ms. G. become addicted?
- What is addiction and what does it feels like? What happens to a person physiologically and psychologically?
- How is addiction to solvents treated?
- How available and accessible are treatment, supports, etc., for pregnant women who are addicted?
- What were Ms. G.'s perceptions about her previous treatment? Why did she refuse the treatment that was offered to her by social workers?
- Did Ms. G. perceive the proposed treatment as culturally appropriate?
- What did Ms. G. want in terms of treatment/support?

In addition, none of the print media's articles discussed addiction as a socio-medical issue (McLachlin's comment on the "ravages of addiction" was the most that was said in terms of the difficulties of treating people with addiction issues). Moreover, none of the articles discussed how substance use and addiction might affect men and women differently; e.g., that there might be different reasons for substance use/dependency for men and women, that society may stigmatize men and women differently for their substance use, and that there might be different approaches to treatment and different patterns for recovery.

Finally, nowhere does the media touch upon the thorny intersection of addiction issues and Aboriginal people, or discuss addiction within the context of colonization, loss of language, culture and identity, abuse, poverty, marginalization and racism.

Discussion of these issues is absolutely crucial in order to understand Ms. G.'s behaviours and apparent "choices." As Callahan points out, these questions were not addressed in any of the Supreme Court documents, most likely because they were not deemed to be germane to the legal case of the Majority and because they would have weakened the case of the Minority. Why the press chose to mirror the Supreme Court and remain silent on these issues cannot fully be known, especially since it would seem that the media have licence to fully and critically explore the issues.

What is Said in the Media About Aboriginal Issues?

That Ms. G. is Aboriginal was noted in only three of the 10 news articles as part of their overall description of her and the case (i.e., after providing a quote by Ms. G., these articles stated: "the soft-spoken Aboriginal woman said"). Thus, beyond saying that Ms. G. was Aboriginal, these articles contained no discussion of Aboriginal issues and how they may have pertained to the case. Moreover, not one of the nine editorials/commentaries included any discussion of Aboriginal issues. Indeed, only in a letter to the editor of the *Vancouver Sun*, one that attempted to put a human face on the "problem" of substance "abusing" pregnant women, were issues of race and racism discussed: "Many of the women we serve are similar to the young Manitoba woman; poor polysubstance users and often involved in the sex trade. Many are Aboriginal women challenged by racism and social isolation."

To some extent, the absence of any discussion of Aboriginal issues in the media discourse is not surprising, since, as Callahan points out, discussion of Aboriginal issues was virtually non-existent in the Supreme Court documents. Presumably, Aboriginal issues were not seen as figuring into the legal case of either the Majority or the Minority, and presumably the print media omitted discussion of Aboriginal issues in order to mirror the Supreme Court discourse. Nevertheless, as has been argued elsewhere in this chapter, discussion of Aboriginal issues is essential in order to understand Ms. G.'s life in context, as well as the life history and circumstances of many other substance-using women. The invisibility of these issues in the media discourse sends the erroneous message that these issues are not important. It is an extremely egregious and yet possibly deliberate oversight – one that perpetuates society's shaming and blaming of individual women.

Interestingly, our search for coverage of the case of Ms. G. within national and provincial Aboriginal newspapers proved completely fruitless. Despite what our research team saw as the critical relevance of this Supreme Court case to Aboriginal people, there was not one article about it in any Aboriginal newspaper.

Why would the Aboriginal media choose not to provide coverage? A number of possible reasons come to mind, including the media's concern about opening up wounds that Aboriginal communities are currently attempting to heal, and/or the media's concern about giving the impression that substance use during pregnancy is (solely) an Aboriginal issue (i.e., fueling internalized racism and as well as the racist attitudes of non-Aboriginal people). When we asked one editor of an Aboriginal newspaper why there had been no coverage of the Ms. G. case, no clear answers were provided, other than the story did not seem to have direct relevance to the readership. After some discussion, however, the editor acknowledged that perhaps the newspaper had "missed the boat on this one."

What are the Aboriginal issues that should have been discussed by the media in the case of Ms. G.? As is discussed elsewhere in this report, Aboriginal people have been experiencing the devastating effects of substance use for generations. Substance use has been both the result of and a response to the process of colonization and oppression, the creation and implementation of the *Indian Act* and the accompanying dismantling of traditional Aboriginal government, and the legacies of residential schools, including physical and sexual abuse, a loss of culture, language, pride, parenting knowledge, guidance and traditions. Ms. G.'s substance use, like that of many other Aboriginal people, may have started out as a means to dull or forget the pain that comes from any of the above circumstances; her substance use may also, or instead, have been a response to low self-esteem, feelings of cultural disconnectedness, or even boredom due to a lack of purpose or hope for her future.

Over time, with the co-incidence of Ms. G.'s substance dependency/addiction and her becoming a young mother, Ms. G. became known to the child welfare and human service systems. Ultimately, several of her children were apprehended by the state. Throughout Canada, there are a disproportionate number of Aboriginal children in government care. How this is experienced by individual families as well as by Aboriginal communities needs to be better understood and could have been discussed in the media discourse. Finally, Ms. G.'s experiences with addictions treatment services, her perceptions of how they addressed her needs as a pregnant First Nations woman, and her ideas for culturally appropriate approaches to promote healing for Aboriginal women could have been explored in the discourse.

Who is Cited and What is Missing from the Media's Coverage?

As has been discussed throughout this chapter, our analysis of the media discourse of this Supreme Court case has revealed that the people who are cited in the news stories and editorials are those who wield considerable power and authority, not only in relation to this case but in society more generally. Not surprisingly, Supreme Court Justices and the federal Minister of Justice were cited most frequently and at length in the media discourse. High-status commentators, such as university professors and spokespeople for national organizations, like Campaign for Life and the Canadian Abortion Rights Action League, were cited at least as frequently and given more prominence than Ms. G. herself. Despite this being the case of Ms. G., her own voice was largely silent in much of the media's discourse.

What other voices were absent? Most notably, the voices of other pregnant substance-using women. These women's stories are at the heart of the debate, yet the media's discourse shed no light on who they are, how they live, how they perceive their circumstances, and what would they recommend as solutions to their problems and the conditions in which they live.

The voices of addictions workers and other human service practitioners were also absent in the media's discourse on the case of Ms. G. A substantial body of knowledge about addictions – not only what addiction is and why people become addicted, but how people experience addiction and how healing and recovery can be promoted – exists, and experienced practitioners could have provided numerous insights into "the ravages of addiction."

Finally, Aboriginal leaders, in particular traditional/hereditary leaders and those who are connected with traditional healing, were also absent in the discourse. Their perspectives on why and how the issues are relevant to Aboriginal communities – and their ideas about how to address the issues within the context of an Aboriginal world view – clearly need to be prominent within the media's coverage of these issues.

The following chapters of this report give voice to these groups.

CHAPTER 4: POLICY IMPACTS
PART I – Perspectives of Substance-Using Women, Aboriginal Women and Human Service Practitioners
PART II – Aboriginal Women Speak Out

By Deborah Rutman, Suzanne Jackson and Barbara Field

Part I

Introduction

In this chapter, we examine this research project's third question: How do existing policies affect substance-using women, Aboriginal women, human service professionals and policy-makers?

This chapter highlights the voices of people who have considerable experience and expertise in the issues at hand: substance-using women, Aboriginal women and those who work closely with them. Despite their first-hand experience, these groups have been all but left out of the policy debate so far. This chapter is presented in two parts in order to provide a more focused view of the issues that are distinct and present in the experiences shared by Aboriginal women who were interviewed.

We begin by profiling the lives of women who use substances while pregnant. Although we appreciate that there is considerable diversity within this group, we also heard strong themes and messages from our informants – messages that provide a crucial context to our discussion of policy impacts. Following this, we discuss the predominant ideologies that underpin current policies and approaches to working with pregnant women who use substances. We then discuss the impact of these ideologies and policies, as well as the impact of the disconnections between policies. A central focus in our discussion is substance-using pregnant women's experiences in attempting to access treatment and their perceptions of the barriers to them obtaining appropriate services and resources. Some of these barriers can be attributed directly to existing policies; others may be more the result of treatment philosophies that, in the end, do not serve the needs of pregnant or parenting women with addiction problems. This discussion includes human service workers' perspectives on the impact of existing policies on their own practice and the women that they aim to serve. In Part II of this chapter, we explore the particular experiences of Aboriginal women and their perceptions of the impact of existing policies and of mandatory treatment for substance-using pregnant women. Although it is true that the effects of substance use on the fetus are indistinguishable among cultures, the factors that underlie and contribute to substance use and the factors that facilitate hope and change do vary; they are also important to consider when contemplating policy and practice approaches to resolving the problem.

Our study is based on a thematic analysis of four focus groups and four in-depth interviews.[1] We carried out one focus group with seven women who were currently involved with a pregnancy outreach program specifically geared for women with substance use problems.[2] Participants included four women who were pregnant, two women who had recently given birth, and the mother of one of the pregnant women who acted as her support person. To supplement these data, we conducted intensive interviews with three additional substance-using pregnant women. In addition, we carried out three focus groups with a diverse group of multi-disciplinary practitioners who work with substance-using women. Disciplines represented in the focus groups included addictions counselling, public health nursing, infant development, midwifery, child protection social work, medicine and hospital social work. Two of the three focus groups involved hospital-based teams/practitioners, and the third involved staff from a community-based needle exchange program. Finally, an in-depth interview was undertaken with an individual with extensive experience as a child protection social worker and as an addictions counsellor.

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[1] Our research process with Aboriginal women is described in detail in Chapter 1.

Context: Profile of Substance-Using Pregnant Women

Although it may seem obvious, it is important to keep in mind that substance-using pregnant women are women who are addicted to or dependent on substances who then become pregnant, rather than pregnant women who begin to use substances during their pregnancy (see Center for Reproductive Law and Policy, 1996; Noble, 1997). Nearly all substance-using pregnant women do not use or abuse substances with the intent of harming their fetus. Instead, they are women who began to use substances well before their pregnancy, who have serious drug or alcohol addiction or dependency problems and who then find themselves pregnant. A number of women also spoke of the tremendous power of the addiction, and how, despite all intentions and "will power," drugs or alcohol can take over a person's life:

> For pregnant women it's hard to focus on the pregnancy when you're thinking about drugs 24 hours a day, every day. Even if you've quit as long as I had, with only screwing up five times.

Several participants in our discussion emphasized that they had a medical problem that deserved recognition as such, rather than being viewed as moral failure on the part of the individual:

> I think there has to be help provided for women. It's not something they're doing deliberately....
>
> It's a fight, every day.... I still dream about drugs. I haven't fixed for four years, but I had a dream just the other day. It's not my fault – it's real. I have a disease; I have a

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[2] As noted above, we appreciate that there are tremendous differences within the overall population of women who misuse substances during their pregnancy. Substance use is not a problem that only affects poor women minority women or younger women – even though these sub-groups tend to fit social stereotypes and are probably the most "visible" and highly targeted groups for intervention services. At the same time, we must point out that the women who participated in our study were accessing services from a program based in one of Canada's poorest areas, and nearly half of the women were from a visible minority. Thus, we did not have the opportunity to interview middle-class or wealthy professional women. Consequently, there is, no doubt, far more diversity in the experiences and perspectives of substance-misusing pregnant women than our study's findings reflect.

> problem. The government should be more aware of this instead of just pointing fingers and sweeping the problems under the rug....

Some women may not know they are pregnant until some months into their pregnancy; others may not learn of the potential damage that their substance use may cause until late in their pregnancy. However, as has been reported in the literature (Tanner, 1996; Bruce and Williams, 1994; Finklestein, 1994), and in contrast to the Supreme Court's dissenting opinion, participants noted that pregnancy presented itself as a window of opportunity to try to turn things around – to address their substance use problems in order to help their unborn child have the healthiest possible start in life:

> I did quite a bit of rock. Then I found out I was two months' pregnant. I didn't realize it 'til then.
>
> But this time I'm going to try not to have my baby born addicted. It's a fight every day....
>
> Me and the baby went through withdrawal. I still do cigarette smoking. I know it's not healthy, but it's better than doing rocks. I'm finally away from it. I'm happy.... I understand rehab situations. I want to give the baby a fighting chance.

Moreover, for our participants, women's motivation during pregnancy to quit or reduce their substance use was prompted not only by their wish to promote their fetus' health, but also by their strong desire to keep the baby after its birth:

> My old man and me, we've been doing prenatal, parenting – all to make sure we can keep the baby.
>
> I don't want the baby caught up in the system. He seems healthy and active so far. I have had three kids prior to this that I never had.

Women's deep desire to parent their baby and not have it apprehended by the state seems to be conspicuously overlooked in most of the literature and media coverage concerning pregnant substance-using women. Indeed, the impression is that "these women" neither care about their fetus' or children's health, nor about their own parental responsibilities; they are said to relinquish their children (presumably because of lack of interest in them) and to have little desire to remain in contact with them. The picture that emerges through discussions with substance-using women, however, is very different. Of course, women's connections to their children are strong and deep. Many women will try to do whatever they can – or have been told to do by authorities – in order to maintain hope that they will keep their child:

> I was told there was nothing wrong with methadone. I did what they [the doctors, people at the hospital and Ministry workers] said. That's the only reason I left with my baby.

And, as we learned from participants in our focus group with substance-using women, when women don't attend case conferences or visit children that have been apprehended, it is not because of disinterest but because of their own feelings of shame and guilt about their addiction problems:

> But my son isn't in my care. Even though I've been here [at the pregnancy outreach program] since my eighth months of pregnancy, they took him away. I don't see him very much. It's too hard....
>
> I was hoping they wouldn't take him away from me. But one night at the hospital, it was 11:00 at night, and the social worker said to me: "I guess you know that your baby is in care." When the case conference came up, I couldn't even come. I felt so guilty.
>
> I wrote a letter to my dad [to give to them] when I was in treatment that their mommy's in a recovery house and that she's getting better and she loves them with all her heart. And that we're going to be together again. But while I was in there I didn't think I could face anybody, and I didn't think I could look at them and say, "I'm an addict and I'm trying to smarten up."

Many participants in our focus groups spoke of their tremendous, relentless feelings of guilt and shame regarding their substance use during pregnancy. For some, it led to suicidal thoughts and feelings of utter despair:

> When I was pregnant, I felt trapped by my feelings of guilt. I was in my eighth month when I came here [to the pregnancy outreach program]. It was then that I read this paper how my baby could be affected, what kinds of damage there could be.... I felt so bad, so guilty, I wanted to kill myself.
>
> I felt so shitty, so guilty [when I was in the hospital]. You feel unstable enough being post-partum.
>
> I stood by the window there, thinking it's up for me and the baby....

Women's own feelings about their substance use is all but invisible in the existing literature and legal/media discourse. The public is led to believe that "these women" basically don't care about the potential harm that their substance use may cause to their fetus or other children. Through our focus group, however, we heard from women about their feelings, and we learned that the depiction of substance-using pregnant women as oblivious and unfeeling is inaccurate and unjust. Moreover, we learned that for some women, their sense of despair regarding the potential harm that their substance use may have caused their fetus led them to "hope" to miscarry; ironically, miscarriage or abortion was viewed as the only viable means to "protect" their child from serious and permanent harm.

Women's feelings of guilt and shame about their substance use seemed to come from within. At the same time, they spoke about how their feelings were fueled and heightened by their perception that society was shaming and blaming:

> And I'm not a suicidal person. But when society makes you feel like you're scum....

Another woman spoke of her profound sense of embarrassment when she was in the post-partum ward of the hospital, and her feeling that, in the eyes of hospital staff and visitors, both she and her baby were less than human:

> At the hospital, they talked about the "addicted babies" in the nursery. That was how they described it to people who were on a tour. I was so embarrassed, standing there in my slippers. I would have liked to pretend I was a nurse there, but there I was, in those slippers. "Addicted babies" – it makes it seems like they're a museum or a zoo or something.... That doesn't help a mother out.

Ideological Underpinnings of Policy and Practice

Women's discussion of how they were treated by human services professionals working in treatment and clinical settings, and about how this treatment made them feel, reveals the issues regarding the philosophies and attitudes that are the basis of existing policies and approaches to working with pregnant substance-using women. Similarly, a central theme and starting point in human service professionals' discussion of existing policy and practice was the philosophical or ideological underpinnings of policy and how ideologies have affected the types of services and resources available, as well as practitioners' approach to working with substance-using women.

A primary facet of current dominant ideologies is their dichotomous nature. Dichotomous thinking, by definition, frames an issue in an "either/or" fashion; with this issue, dichotomous framing leads to the pitting of a woman's interests against those of her fetus. Consequently, dichotomous thinking can create or augment differences or conflicts between parties. Moreover, because of the "either/or" nature of the problem framing, dichotomous thinking limits creativity in identifying effective solutions to problems or in resolving conflict.

Dichotomous thinking clearly is evident in how issues concerning substance use during pregnancy are framed. One informant who had extensive experience as an addictions counsellor and a child protection worker noted that dichotomous thinking was predominant in the child welfare field, and was demonstrated when professional concern was directed at either a mother's health or the unborn child's health, and when a woman's "rights" and "best interests" were pitted against those of her fetus. This informant noted the extent to which this type of thinking had become firmly entrenched:

> ...[W]e say, "Wait a minute, that's a unit. How do we find an analysis that doesn't automatically put us into an adversarial place?" And you find it's really difficult.

Participants suggested that Canadians need to see substance use during pregnancy as a health and social issue, not one that positions a woman "against" her fetus or baby adversarially. Practitioners also described the necessity of working actively to help women feel they weren't disposable, despite the serious nature of their problems.

Predominance of an Abstinence Model

According to service providers, current policies, programs and practice were grounded in an abstinence model for the treatment of addictions. Participants described this model as being dichotomous in that it was "all or none" or "black or white," and assumed and required that people with substance dependencies could "just say no." Anything less could be considered personal failure. Indeed, our informants suggested that an abstinence model had shaped the biases and expectations of practitioners, thus creating a lens through which progress was monitored. These expectations, or "magical thinking" as one informant referred to them, also often led to a pass/fail, shame-based mentality by social workers and the women they are trying to assist. The limits of this approach for marginalized women with complex and multiple problems, whose addictions may have spanned 20 years or more, were clearly expressed as follows:

> If abstinence is the only outcome you can see as a sign of success, then of course you are going to see everybody as non-compliant, resistant and in denial because not everybody can do that in the time we can have with them.

Practitioners also noted that the attitudes of the media and the public generally mirrored and reinforced the abstinence ideology that is evident in policy:

> The community's answer for treatment is: "Just stop that. Get off the street and get a job – get a regular life."

It was noted that the historical treatment model from which many programs and policies had developed was based on research findings with white, middle-class males. Although an abstinence approach may have been effective with men, our informants suggested that those findings are not applicable to a multi-ethnic, poly-drug-using group of pregnant women. Indeed, the professionals participating in our focus groups and interviews were extremely critical of an abstinence ideology, and in fact were actively working to implement a harm-reduction model within their hospital and community-based work settings.

The Effects of Abstinence Models and Ideology

From the perspective of our participants, an abstinence model did not recognize the realities of people's lives, including why people used substances, what other issues people were contending with, and what purposes substance use might serve. Taking this last point further, informants posed important questions:

> [We] need to understand the function of the behaviour in the individual's life: how does the coping mechanism work? Why? What does removing it do?
>
> For example, does [the] use of heroin keep [a woman] from shaking [her] baby because he or she is colicky?

In addition, an abstinence model didn't recognize that recovery and healing were processes that took considerable time and tremendous effort, most often involved relapses and backslides, and were best measured in very small steps:

> The difficulty, I think, for our clients, is...ADP [alcohol and drug programs]... policies: No alcohol on the premises at any time. Their goal is zero tolerance. And so there are people looking to cut down and just improve their life, and maybe they see that as a long-term goal, but they are taking small steps to reach that, and they need the small steps. It's just too much to accept the fact that you've got to agree you are never going to use again.
>
> In the alcohol and drug world, the process has to normalize slips. Relapse isn't to be seen as a failure. It's an opportunity to learn something.

In a similar vein, substance-using women strongly emphasized that women's every step toward recovery, however small (or even followed by a backward slide), needs to be appreciated. When this doesn't happen, when there is no recognition of those small steps, women feel demoralized and unsupported. This can constitute a real barrier to accessing treatment, as our participants shared with us:

> I was trying, even at that late date, to do something. And they didn't listen....
>
> But now, I have a beautiful apartment. And I have food! I have coffee and tea and sugar and milk in the fridge! And soap. People overlook that. But if people could see that. It's those stupid little things like that, that mean a lot.

An important point here is that women need to have the "space" to voice their sense of their progress (and setbacks), and those working with women need to be especially attuned to the significance that these milestones, however small, might hold.

According to participants, an abstinence approach to treatment often created additional barriers to people's accessing support, and even constituted grounds to refuse a person's admission to a recovery program. For example, in some programs adhering to an abstinence model, a person would be required to be completely clean for up to four weeks prior to entry to a program, and would be expected to remain entirely sober for the full duration of the program. Barring a person's admission to a treatment program because they were not sober could likely mean that the person would continue to use substances and in the process endanger themselves, and in the case of pregnant women, their fetus. As one participant put it:

> Right now, it's all or none. You just say no to drugs – you are clean and sober or you don't get service. And what we are realizing is too many people are going to die or get sick before they get to any place of abstinence. So the question is how is the service shifting to see that people that are actively using are in need of service now.

The Assumption/Ideology that Parents Who Use Substances are Bad Parents

A second set of dichotomous assumptions and beliefs that are evident in child welfare policy and prevalent among many practitioners is that parents who use substances are not – and perhaps cannot be – "safe" or "good" parents. These assumptions, similar to and seemingly derived from an abstinence model in that they reflect "all or none" or "pass or fail" thinking, have greatly influenced current child protection policies, risk assessment protocols, and the practice of multi-disciplinary family health professionals. For example, one practitioner spoke of how this ideology had so influenced child protection social workers' decisions about whether a substance-using mother could care for her child(ren) safely that the decision-making process became, in effect, formulaic:

> I don't know if this happens [here], where...the question [becomes] is a woman using? Isn't she using? Oh, she's using. She must go to treatment now. She doesn't go to treatment, she doesn't get her baby. And it's like this: kind of…a built-in formula.[3]

Similarly, another participant voiced her frustration with professionals whose practice decisions were seemingly guided solely by their attitudes or biases concerning parenting and substance use:

> And it's very frustrating when there is somebody who has just started their job and they are not going to listen to you, who's been doing this for four years or more. And that's what happens. I mean, you get this total breakdown on, well, "How can this person be able to parent if they have got a drug problem?" Or the part that even gets worse than that is: "Well, they have HIV. I have to apprehend the baby." And it's like, "No, that has nothing to do with their parenting ability." "But if they are using drugs and now they have HIV, they are going to die anyway. Can you phone the doctor for me? We need to make a big planning meeting of where this child is going to go because this person is going to be dead in a year." And then we have to go through the whole process of explaining that that is not going to happen.

In discussing this ideology, informants reminded us of the need to think critically about how history and politics shape our thinking. For example, one informant stated that he believed the U.S. was on drugs campaign created images of "noble allies and despicable enemies." This paved the way for workers and the public to view substance-using mothers in a highly negative light and to hold attitudes that would prove extremely difficult to "unlearn." One informant's critical reflections led him to point out an underlying hypocrisy in society that suggests that there are "good" and "bad" drugs; in reality the "good" drugs (nicotine and alcohol) cause harm to far more people than all other drug use combined. He further urged people to consider:

> Who benefits from this dichotomy? Who funds Partners for a Drug-Free America? The pharmaceuticals and the distillers, who are invested in a good drug/bad drug program.

Effects of Assumptions and Ideology that Parents Who Use Substances are Bad Parents

Practitioners participating in our focus groups voiced their strong concerns regarding what they viewed as a significant ramification of the ideology that persons who use substances are bad parents. The current trend in the child protection system is to regard parents' substance use as reason, in and of itself, for a child's apprehension. Our key informant and focus group data suggested that the dichotomous framing of this assumption obscured the complexity of the issues. While participants were in agreement that there can be an association between out-of-control addiction and child neglect, and while no one denied that parental substance use was a real problem, participants nevertheless believed that the media's dogged criticism of the child welfare system had effectively pushed policy-makers and practitioners to adopt a punitive approach to working with families affected by substance use. Moreover, participants worried that this approach was counter-productive and would lead to poor outcomes for both children and parents:

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[3] See footnote 1 in the preface to this report for a brief description of the harm-reduction model.

> [W]e are getting increasing calls because of this scrutiny that the media is doing. I've been getting these calls…from people saying, "Should I return a baby or should we be doing urine screens on mom and dad?" And I am going, there is a witch hunt a-brewing here – and a slippery slope if we don't start kind of naming some of these things broadly and using models of what might be working effectively.

For their part, substance-using women are acutely aware that many professionals hold negative and prejudiced views toward them because they are pregnant or parenting. As noted above, many women already experience tremendous feelings of guilt and shame about their substance use during pregnancy; however, it seems that these feelings are often fueled by the women's perception that workers are shaming and blaming, that workers pre-judge women because they are "addicts," are lying and deceitful, and unfit, uncaring and even abusive as mothers. One woman told of an experience involving a social worker who brought the police with her when making a home visit to see the woman's baby:

> But one social worker, she brought some cops to my place. It was like a drug raid. They wanted to see the baby. She was fine; she was sleeping.

Women's distress about practitioners' blaming and prejudicial attitudes was heightened by their recognition of the power that certain professionals held, particularly in relation to child protection and apprehension issues. Participants expressed that they generally felt powerless in their interactions with medical and/or child welfare authorities. Moreover, their feelings of powerlessness were exacerbated by their belief that professionals' prejudicial attitudes prevented them from seeing women as individuals and from acknowledging women's efforts toward recovery. As one focus group participant shared with us:

> Here's a story: I love my husband. When I was in the hospital with my last baby, I was so happy to see my husband. I mean, I really wake up in the morning, and there he is, with his morning breath and all, and I can just say, "Babe, I love you!" But when I was in the hospital, there was one nurse who said that he was giving me drugs. Like, that's why I was happy to see him, because he was giving me drugs. I felt like that one nurse, she had so much power….

Professionals also noted that substance-using women were highly aware of the Ministry's current stance, and as a result, women were both afraid of coming to see Ministry workers and were afraid of the outcomes of such interactions. In addition, informants appreciated that as a result of prevailing attitudes toward substance-using parents, some women might choose to lie to or withhold information from professionals:

> The reality is if they are honest – I meet women who lie to their social workers – they tell me that they are not going to say something because ultimately it's out there and they know that their baby is possibly going to be apprehended.

Overall, the impact of women's experience of practitioners' prejudice and their sense of powerlessness was a deep fear and distrust of many professionals. Women's fear was palpable, ever-present and borne of troubled and demoralizing experience. Their fear also had a specific focus: that their baby would be removed by child welfare authorities. Moreover, their fear seemed heightened by their recognition of the Ministry for Children and Family's current practice/policy to earmark parental substance use as a high-risk factor, one that often contributed to child apprehension orders. One woman described her anxiety regarding what she believed to be her doctor's power to apprehend her baby:

> Some people are so prejudiced. For example, the doctor at the hospital. She didn't like me. [I still worry] that she's going to find some way to take my baby away.
>
> Then being at risk of losing your baby [to the Ministry for Children and Families].... All it takes is one person who's against you.

As has been found in the literature, women's distrust and fear could result in their seeking to avoid alcohol or drug treatment and medical or prenatal care (Goldberg, 1995; Metsch et al., 1995; Noble, 1997). One focus group participant spoke on this issue by vowing to travel to another province to deliver her baby in order to help ensure that authorities would not apprehend her child on the basis of what she deemed prejudice (as, in her opinion, had happened before).

> [Crying]. I will leave B.C. to have this baby. I'm so scared. My apartment is fine. I even have furniture. But I'm so scared that they're going to take away my baby. I've been through this before. I was clean for four months. But they still took my baby. I had her for two days before the bailiffs came in to take her away.

Similarly, another participant acknowledged that her profound worries about being judged by workers had in fact delayed her efforts to seek help or treatment. To her surprise, she found that the professionals involved in the multi-disciplinary pregnancy outreach program that she ultimately attended were extremely supportive and non-judgmental:

> When I first came here, I was scared. I would have come earlier had I known about it. But I was terrified that I would be judged. But they care; they genuinely care.

While it was extremely fortunate that this woman did overcome her fears and found a program in which she perceived the workers to be non-blaming and caring, the ending of this story does not take away from the points that: a) for much of her pregnancy, this particular woman continued to use substances and avoid treatment in part because of her concerns regarding possibly disrespectful treatment by professionals; and b) overall, women avoid treatment because of the dominant women-blaming and punitive ideologies and prejudices that guide existing policies and professional practice. Clearly, pregnant women's avoidance of addictions treatment or prenatal care is a potentially disastrous consequence of current practice and policy. It is an unintended outcome that, ironically, could result in significant harm or neglect to both women and children.

Along these lines, substance-using women spoke emphatically about how their worries regarding their baby's possible apprehension, apparently instilled or reinforced through scare tactics by some professionals, had the adverse effect of heightening their addiction problem:

> I'm so scared they're going to take my baby away.... They think that'll make me better. But what they do is [make] me a worse addict.

An even more direct connection between actually losing a child and abusing substances was made by women whose children had been apprehended by the state. Some women spoke plainly that, after their child(ren) were removed, there was little reason to remain clean and sober:

> After they took my baby away, I was on the phone with my dealer in half an hour.

> I have to keep remembering how happy I was before I was addicted, when I was in control of my own life.... After I lost my kids, I thought, "Who the hell cares?"

The women's point was clear: why would they bother about staying clean when that which they cared about most – their children – was gone? In view of women's experiences, their sense of hopelessness and the self-destructive behaviours that could stem from their feelings of futility were understandable. Women's experiences also have clear implications about the effects of existing policies and approaches, and in terms of directions for alternatives. For substance-using pregnant women, using threats, fear and intimation that a child will be apprehended if they continue to use is a major barrier to women's recovery. Fear heightens women's addiction problems. Alternatively, having the hope of keeping their child(ren) is a major motivator for women to quit or reduce their drug use. As one woman told us, speaking about the importance of instilling hope:

> G.'s my favorite nurse. There was this one time, and I screwed up, and I got really scared – what would this mean for the baby? But G. said, "Don't feel guilty. Your baby's active." That's the kind of people we need. When I come down, it's people like G. I have to talk to.... Before I got here, I wanted to kill myself.

Predominance and Effects of Dichotomous Thinking in Relation to Child Welfare Policies: Child vs. Family Focused

In discussing existing ideology, policies and practice, participants also observed that policy-makers and professionals continued to engage in dichotomous thinking in relation to "child-focused" versus "family-focused" practice. In examining the question of how of existing policies have affected substance-using pregnant women and those who work with them, this policy debate must be flagged, both because dichotomous thinking arguably runs counter to both a family health approach and to women-centred treatment models, and because it has influenced the practice of many professionals who work with substance-using women/mothers:

> I think you have conflicts because we from the pediatric community point of view have a very child-focused approach.… And I think that some of colleagues that we interact with bring a more family-focused approach, a parent-focused approach. It does inevitably mean occasional disagreement when you are kind of more batting for the mom in the family than maybe you are for the baby.…

This longstanding issue has plagued the child welfare field for decades and has resulted in pendulum-like swings in policy and program development. Although many observers and workers in the child welfare system have been highly critical of such divisive, "either/or" thinking – arguing instead that wholistic family-focused practice will fundamentally benefit children as well – overall, dichotomous thinking seems firmly entrenched. Currently, largely as a result of the 1995 Gove inquiry, child welfare policy in British Columbia has emphasized the interests of the child. This swing toward child-focused practice also has been fanned by the media's (and the public's) scrutiny and ongoing criticism of the Ministry for Children and Families.

Participants observed that, as a consequence of such intense public and government scrutiny, the Ministry's message to front-line child protection social workers was that they would be held personally accountable for removal decisions and their outcomes. As a result:

> [Ministry social workers] are coming in with no alternatives, and they are under the gun right now. They are scared out of their minds that they are going to lose their jobs. And so they are coming up with the most cautious approach that they can think of, which is removal. Which is probably the worst possible time to remove the baby – at birth.

Professionals were sympathetic to the issues and pressures facing these social workers; indeed, participants' comments indicated that they considered that this policy direction, by instilling fear and "cover-your-ass" thinking, had serious, negative ramifications for practitioners as well as families. Nevertheless, participants were most concerned about the negative impacts for families of the policy direction to remove children as a "less-than-last resort," especially when removal came at birth.

Predominance and Effects of Stereotyping, Homogenizing and Ghettoizing Women Who Use Substances

Finally, in discussing dominant ideologies and their impact on policy and practice, participants spoke about the public's – and professionals' – tendency to ghettoize women with substance-use problems:

> I agree that it has got to be across the community, not ghettoizing, which was our great fear. That the minute we start talking about substance-using women, in people's mind's eye, it's a ghettoized population there. And it isn't.

> I think they have to understand it could be anybody in all walks of life. Because if I say I've met teachers, I've met a minister, I've met people who work in a bank,

> people who drive a school bus. No, we so want to stereotype it; it's not just an average Joe Blow like us.

As participants pointed out, ghettoizing women with substance dependency or addiction issues turns them into a homogeneous group of, presumably, indigent, welfare-dependent, possibly homeless, marginalized and, more than likely, Aboriginal women. Ghettoizing renders women's individuality and their unique circumstances, experiences and needs invisible. Moreover, ghettoizing can lead to professionals limiting and focusing their outreach efforts on those women who they expect will fit prevailing racist and class stereotypes of a substance-using pregnant mother. It becomes in effect a self-fulfilling prophecy as certain groups become over-represented in the "affected" and "targetted" population:

> First Nations people, women are disproportionately criminalized for their drug use. If you are a lawyer who has a regular heroin habit in Kitsilano, how likely is it that you are going to come under the scrutiny of the state?

Participants felt strongly that substance-use problems transcend race and socio-economic categories, yet the images created of substance-using pregnant women as the impoverished woman on the street corner trying to score her crack, left little encouragement for middle-income women, for example, to identify their needs to helpers. Consequently, informants felt that the majority of these women remain isolated:

> I think that we sometimes carry this image that a drug user is this down and out groveling sort of person and they can be very middle class or very together looking – but they are doing drugs prenatally.

Policy Disconnections and Disjunctions

Disconnections Between Policies in Different Arenas

Practitioners were highly critical of the lack of connection and coordination between the policies of key ministries, in particular, the financial assistance policies of the Ministry of Human Resources and the child protection policies of the Ministry for Children and Families. Workers spoke of women getting "caught" in different ministries' policy debates around who could or would do what. Practitioners also appreciated that while women's daily struggles were largely because of poverty, they were also exacerbated by women's frustrating experiences trying to access resources from ministries that seemed nonsensically disjointed, and by demands that women attend programs without their having the means to get to them:

> So ask that mother to put herself in very poor living conditions and then say, and now not only that, but you have to go do these parenting courses and you have to do this and you have to do that, and running around and trying to get a bus pass from financial aid is sometimes a headache in itself. I mean, I couldn't do it. I really couldn't.

Women are Set Up for Failure

Participants suggested that these policy disconnections created tremendous stress for women and ultimately could have the effect of undermining a woman's efforts to prepare a safe living space in time for her baby's birth. Obviously, if a woman could not summon the resources needed to provide such a safe space, she risked having her child be removed by the state:

> ...When [women] are not really issued any kind of financial supports to help them prepare for the baby until the baby is just about out the door. So [the financial side says], we are not going to fund you to do these things, while the protection side is looking, scrutinizing how ready you are, what preparations have you made, what kind of housing do you have.

People are Punished for Their Substance Use

Participants also were extremely troubled by recent changes to income assistance policies that no longer entitled people to bus passes in order to attend drug and alcohol treatment services. From practitioners' perspective, these policy directives were grounded in a punitive ideology, and they created yet additional barriers for women to receive the healing support they needed:

> ...so that alcohol and drug services will no longer be considered eligible for bus passes. So that means that all of our clients that come to our day program and relied on the bus passes to get there, now have to find a way to get there. And it's either we pay for them to get there or they don't get there. So tell me how that makes any sense when we are working with this population.
>
> So we are punishing. If you have an alcohol and drug problem, you get less financial assistance.

In discussing disjunctions between policy areas, several practitioners also noted the negative impact that a major police sweep of "street workers" had had on practitioners' ability to connect with and provide outreach services to their clients:

> We go out there, and we try to make ourselves available in areas where drug use is prevalent. Oftentimes we'll find people walking around the street, stop them, ask them if they need service. I know before there was this big police swoop of the female street workers, and since that swoop, they haven't been on the street anymore. We're kind of disappointed at that, we're not reaching as many of them as we were, let's say, two years ago.

While this sweep apparently "sanitized" certain sections of the municipality and thus served business and tourist interests, it also resulted in women substance users going underground, and their no longer accessing known outreach treatment services. In addition, the police action contributes to a shaming and blaming ideology that legitimizes the idea that "these people" can be pathologized and thrown away.

Lack of Coordination and Communication in the Family Health Field

In addition to discussing disconnections and lack of coordination between ministries and/or different policy arenas, participants also raised the perennial issue of a lack of coordination among disciplines or service areas within the family health field. Specifically, participants felt that alcohol and drug services and the child welfare system needed to have a better appreciation of one another's mandate, philosophical approach, services and resources. At the core of this was the need for better communication between multi-disciplinary/multi-service professionals:

> I think communication is a huge issue, and it's getting a lot better. But you know, we still have experiences where we work with a woman quite exclusively, quite a lot and then I happened to be in the hospital and found that the baby is being apprehended. And it's "What?" And the Ministry had no idea that she had been working with Sheway or with Safe Passages....

Another participant voiced a similar concern:

> I think, too, that you are basically looking at two systems – the child welfare system and the alcohol and drug services system. How do they interface? And, I mean, I don't know, but my knowledge is that we don't do as well as we need to.... But I think in order to be able to appropriately assess a woman who is using substances and her ability to parent, the child welfare system has to have more information about [substance use], harm reduction and parenting.

Revealed in the above comments is another key issue that was expressed by participants: that an unequal power relationship existed between the child welfare/protection system and the other disciplines/service areas in the family health arena (e.g., alcohol and drug treatment services, public health, etc.). To many practitioners, it felt as though the child protection system was driving the practices and policies of the other service areas. This had significant effects for both workers and women. This notion also relates to and could be grounded in the ideologies (e.g., dichotomous thinking; "paramountcy" of the child) discussed in the previous section.

Workers Experience Role Confusion and Frustration

Several participants noted that the disconnection between, and seeming pre-eminence of, the child protection system over other service domains resulted in role confusion. One public health worker spoke of dilemmas she experienced and her frustration that her clients' needs were not being met:

> There are times when I feel like I am walking in two different trenches....What is my legal obligation? I find now that people will call the health unit – they are desperate, they feel guilty, they may have gone off or onto drugs again, they are pregnant. What's my job as a public health nurse? If I say I have to report this to the [child protection] Ministry, that I am obligated to flag this at the hospital, you could have a mother that immediately goes underground and they are going to immediately disconnect from me. So I am really confused as a practitioner – what my role is as a child protection sort of worker: to comply with legislation or expectations of me

> versus building up some sort of a relationship with that woman, working with her and seeing what's going to work best. I feel like I am in two different places and that I have had no direction.

Women Avoid Accessing Treatment

According to participants, policy and practice disconnections have not been ameliorated by the creation of the British Columbia Ministry for Children and Families through the amalgamation of several key service areas (public health, mental health, corrections, alcohol and drug treatment and child welfare/protection) into a single Ministry. In fact, participants felt strongly that merging addiction services within this new Ministry proved to be very frightening for some of the women with whom they worked. This was particularly so when women had to go to an office associated with "child protection" to get counselling for their addiction concerns. Indeed, professionals suggested that co-locating alcohol/drug services and child welfare services seemed to come at the expense of ensuring that women with substance-use problems received the support they needed:

> Alcohol and Drug Service[s] now being part of the child protection Ministry is proving to be a barrier, especially for moms who are substance-using. Because when they go into the alcohol and drug office, the first thing they see on the door is Ministry for Children and Families – Alcohol and Drug Services. I have talked to at least four mothers who have said, "I got to the door and I turned around. I was so scared they'd take my kids."

Addictions-Related Training is Insufficient

Taking the above points one step further, participants noted that it was problematic that workers in some disciplines received training in relation to addictions, while other practitioners did not. In particular, participants emphasized the need for child welfare workers to have more in-depth training and knowledge regarding addictions, particularly in relation to parenting. Participants felt that it was both professionally irresponsible and unacceptable to grant child protection workers the powers that they held, unless they were as knowledgeable as addictions counsellors in the area of substance use. Participants' comments also illustrated the dangers of combining professionals' lack of knowledge with their abstinence-oriented attitudes and prejudices against substance-using parents:

> If you give, as a society, power to one group of individuals to take children away from families, you better make sure that they also have the understanding and the knowledge of all of the dynamics. And they do not. And when drugs and alcohol are factored in, I don't know what the percentage is of the apprehensions, but I would suspect it's very high, if they don't have.... They should be as well trained as any of us in this room, or drug and alcohol staff at [the treatment centre] on those issues. And they are not. And that's appalling to me.
>
> I've had social workers say, "I don't know when I should worry." If they are dealing with children, they can look for signs of abuse or whatever, but as far as dealing with the parents, they don't know necessarily, like how much use is bad. Because if you are raised to believe anything is just awful, you only go by what you know.

Participants appreciated that most of the social workers that they knew were hungry for professional development in relation to substance use; unfortunately, however, social workers' workload and caseload responsibilities tended to prevent them from having the time to engage in in-depth training. This point has ramifications for policy shifts in training requirements and workload adjustments for multi-disciplinary practitioners working in the family health field.

Finally, participants discussed policy disconnections in relation to other areas within family health – even apart from the child welfare system. These disjunctions were seen to foster both workers' and women's lack of understanding of the complexity of the underlying contributors to addiction problems:

> System policies disconnect parts of people. For example, in relation to sexual abuse disclosures, alcohol and drug workers are told, "Not your issue, refer elsewhere." Lunacy! They need to understand that by asking the person to give up drugs you may be asking her to give up sex, as the only way she may be able to have sex is by using drugs which protect her from the pain of earlier sexual abuse.

Concerns were also expressed about the disconnection of most family physicians from the care team, and how this has implications for early identification of and assistance to pregnant women who are using substances.

Scarcity of Treatment Resources and Options for Pregnant or Parenting Women

Comments regarding how available resources affect substance-using pregnant women focused on issues of the appropriateness of design, timeliness in terms of need, and barriers to access. It was generally agreed that by policy, pregnant women should be admitted to whatever kind of treatment service that is compatible with their particular needs as soon as they request the assistance. However, the reality for women was seen to fall short of this ideal.

(In)appropriateness of Existing Resources

In discussing existing treatment resources, human service practitioners echoed substance-using women's fundamental criticism of the system: there is an absolute dearth of treatment options for women who are either pregnant or parenting. As participants from two different focus groups told us:

> But there is nothing. We don't have...a resource where a woman can go. We can't even get them into a short-term stay place where they can find housing.
>
> Where will the women who are not court-ordered for treatment go? I've met women who were pregnant and would love to take that opportunity and there's nowhere to go.

In addition, practitioners and substance-using women alike questioned the appropriateness of most of existing resources and programs for pregnant or parenting women; i.e., although traditional detox facilities may exist and be appropriate for other user groups, participants questioned their appropriateness for many women, particularly those who were pregnant or parenting. According to participants, most programs did not recognize that pregnant and parenting women had unique issues and needs, or that different women had different needs. In discussing the appropriateness of existing treatment and healing resources, participants noted that key dimensions of "appropriateness" included cultural appropriateness, gender appropriateness (i.e., recognition that treatment approaches used successfully with men may not be appropriate for women), and substance appropriateness (i.e., recognition that treatment approaches used successfully with people with alcohol addiction or dependency may not be appropriate for people with heroin or solvent abuse problems, or vice versa).

For example, several women spoke about the lack of fit between existing treatment facilities and resources and the needs of pregnant women. Women noted that even if a recovery facility were culturally appropriate and staffed by ex-users, it could still be unsuitable for them if there was no recognition of the particular needs and circumstances of pregnant women:

> Not just people who have used. You need to have a place that's specifically for pregnant women. At the recovery home there were people who had used, but I was the only one who was pregnant.

Indeed, one practitioner also noted that her own and her colleagues' efforts to collaboratively revamp women's treatment services and to implement a harm-reduction approach within several institutional settings resulted from:

> ...recognizing that these women have not been well-served, and that they have fallen through the cracks. And that they have been screened out of traditional alcohol and drug services.

Effects of Inappropriate Treatment Options: Women Drop Out

Practitioners found it sad and frustrating but completely understandable that, consequently, women tended to drop out of existing treatment services:

> You can admit the women here, [but] they only have four beds and [this] isn't the ideal facility. They get bored out of their minds. They are lonely and it's a very different, very middle class, very different people. There is no one really to relate to and so that's often what drives them away more than anything else, is that they are lonely and bored. And they are back out there again. And that's incredibly frustrating. You know they want to go into treatment [but] there is nowhere for them to go with babies.

(Un)timeliness of Existing Resources

As noted above, pregnancy can be an important "window of opportunity" for women with addiction problems, a time when women are particularly motivated to try to quit or reduce using, or to seek treatment and support. When women make the decision that they are ready for treatment, they are looking for immediate assistance. Having anyone with substance-use problems wait weeks if not months to access services is shameful, but it is all the more unconscionable for pregnant women. Nevertheless, that is the experience of many women in British Columbia, including some of our focus group participants. One woman told us, for example, that she continued to use heroin for an entire month in the midst of her pregnancy before there was a space available in an appropriate treatment program:

> I had to wait a month before I could get into the program at the hospital. That was hard. I was still using for that whole month while I was pregnant.

In addition, mirroring women's criticism that treatment programs are not available when pregnant women need them, professionals spoke of the need to ensure that a range of treatment options were available for pregnant women at all times:

> And the reason why that is so important is because often that is where the woman's readiness is at. She may not have been able to, for a number of reasons, been ready to access support services to assist her with getting ready for parenting and to address her drug dependency issues. But she will probably be as close as she is going to be at birth. So you want to grab that woman, right then and there and just, you know, assist her.

This comment reveals two important ideas: that there needs to be a variety of resources and programs available in recognition of the diversity of people's circumstances and needs, and that women's "readiness" for treatment may vary. In other words, readiness is not an "all or none" state that is experienced in the same way and with the same treatment implications for all women.

Effects of Untimely Resources: Windows of Opportunity are Lost

Practitioners echoed women's views that an inability to access services immediately – in line with women's readiness – could mean that crucial recovery and healing opportunities are missed.

> The thing with referrals, we referred someone to Alcohol and Drug Services yesterday and they are downsizing their services at an enormous rate themselves. So we're in to a two-, three-week wait, and the window just doesn't stay open for that long.

Another practitioner shared what was for her an eye-opening story of a woman who tried repeatedly and unsuccessfully to access alcohol and drug treatment services:

> It's really an experience to go with someone and find out what's it's like. [She's] really gung ho, and [she] goes in, and they say, "I'm sorry, we can't see you now. Come back in three weeks." And then [she] goes in and they say, "Oh, I'm sorry, your appointment is cancelled today; the worker isn't able to help you, but you can come back at Thursday at 4:00." When [she] comes back at Thursday at 4:00, they say, "Oh, he got called away. Do you think you could come back tomorrow at 2:00?" By the time [she] goes through all these hoops [she] is crazy.

As this worker pointed out, the impact of these "crazy-making" delays could be that a woman's patience understandably becomes exhausted and she no longer is interested in treatment.

Unfortunately, her disinterest may be interpreted as "resistance" and used to her disadvantage in the future.

(In)accessibility of Existing Resources

Substance-using women spoke about the "military"-like atmosphere of many treatment facilities. Inflexible rules and unyielding attitudes of practitioners working at treatment centres were viewed as a major barrier to women's recovery. For example, one woman spoke of getting "kicked out" of a treatment facility because her partner and daughter came into her room:

> The Director has a real attitude. I was there for eight days....But I ended up getting kicked out by the Director. My 15-year-old came into my room with my boyfriend – there wasn't supposed to be anyone in the rooms with us – and the Director ratted on them. I looked at her and said, "we heard you." And then I got kicked out because I wouldn't apologize. I was told I had a bad attitude. And then she wouldn't give me my welfare money or even a bus ticket.

Clearly, the "hoops" that are created by services that are grounded in an abstinence philosophy pose real barriers to this vulnerable population. For example, one practitioner spoke of a situation in which a woman with a long-standing addiction to heroin and cocaine requested help from a local women's treatment centre. Like many, this centre's eligibility policy requires women to be "clean" of substances for four weeks prior to entry. One week before this woman was due to come in, she smoked a joint; consequently, she was no longer considered to be clean. She thus became ineligible for treatment, even though she did not use either cocaine or heroin during that four-week period.

This example raises many issues and criticisms; however, the practitioner's main point in sharing it was to illustrate how inflexible policies resulted in lost opportunity for a highly motivated woman to help both herself and her developing baby. He also saw it as a further illustration of how adherence to an abstinence model is entrenched in operating policies, despite an articulated policy of prioritizing treatment availability for pregnant women and support for the tenets of harm reduction.

Although it may be important to have ground rules to guide the behaviour of clients of treatment facilities, clearly it is counter-productive to terminate a person's treatment because she is unable to completely adhere to these rules or because of personality clashes with staff – all the more so in the case of pregnant women. Arguably, treatment facilities need to be as flexible and accommodating as possible, especially for pregnant women. Women's desire for treatment, their interest in their own healing and the health of their fetus should drive the approach used by facilities in working with them.

Ideologies in Transition: The Process and Effects of Implementing a Harm-Reduction Model

A number of workers recognized that harm-reduction and abstinence-based approaches are evident in policy and practice in this field. Thus, we are currently in a time of philosophical transition, accompanied by tensions and debates as the ideologies of both are influencing developments in the field.

Perhaps not surprisingly, participants spoke of practitioners' struggle with this transition, depending on their location within the care continuum (i.e., whether they are working primarily with the substance-using woman or with the withdrawing baby) and the opportunities they have to reflect on the origins of their own attitudes and biases:

> It has not been easy.... It has not been easy for us as a committee to get consensus, but then when it gets down to the practicalities for each individual woman, how does that play itself out? And then how do you get a shift in practice? And that, you know, has been our struggle for the last two years.

There have also been struggles having a harm-reduction approach be endorsed and adopted by all "arms" of the family health system, and in particular by the child welfare system. Participants felt that the Ministry for Children and Families still had not committed itself to a harm-reduction model and that the Ministry's stance was contributing to practitioners' difficulties:

> So the Ministry has to decide that it is going to adopt the concept of harm reduction. That it is going to expect that the people who are working within the Ministry work with those guidelines. And it's unacceptable not to. And it is going to ask for feedback from the people it is serving. I don't think it really is paying attention to that.

There also has been considerable confusion around the meaning of "harm-reduction." Participants spoke of how, initially, practitioners likened harm reduction to taking a completely "laissez faire," non-interventionist stance. However, participants argued that a harm-reduction approach required that practitioners consider and be accountable to address multiple facets of a person's life that may result in harm.

> By definition, harm reduction makes the person who is practising harm reduction accountable for recognizing the harm. It also makes them accountable for minimizing that harm once it's recognized. So it's almost opposite of being laissez faire. It's making you accountable through...looking at the family and saying, "Where is the harm that is coming to this family? What can I do? What is my responsibility to reduce that harm?" And to give you a simple analogy or example – and it's not drugs we are talking about – I am talking about poverty and housing and everything else. This hospital, when it developed the policy of sending women out after two days post-partum...we had women from the west side going up on the antepartum home care program and coming back. Two babies came back with irreversible neurological damage because they weren't getting the follow-up. And almost ironically, these high-risk women and families, who we kept in for a week or so until we knew that they had safe housing, [that] the baby was gaining weight, and [that] we knew there was follow-up – we never had any problems post-partum. Because we recognized, we looked for the harm, we recognized it and we minimized it. And that's when harm reduction works. So, if anybody says to you, "Oh, that's just a way of blurring

> things," it's not. It makes you accountable for recognizing the harm, and makes you accountable for actually minimizing it before you send that person out of your care.

Although participants noted that many professionals were increasingly appreciating that harm reduction needs to be seen as part of the same spectrum as abstinence and not as a dichotomy, some confusion still exists. One participant suggested that this was perhaps best illustrated by the following question: How do you describe a woman on methadone – is she on a drug or is she in recovery? Participants noted that this question was causing real problems for pregnant women who shifted to methadone in the belief that they would be reducing the harm to their baby, yet who heard themselves being described as bad mothers because of their substance use while pregnant.

Despite some workers' difficulties during this transition period, participants emphasized that, overall, practitioners were quite positive about adopting a harm-reduction approach because it enabled them to engage in more wholistic practice with women and families, and to help effect and recognize positive changes in demonstrable albeit small ways. As participants told us:

> By changing the approach and educating and looking at the whole woman in a different way, and her addiction issues, you can buy into the harm-reduction model with a real sense of: if we've only been able to open the window a little crack this time, maybe that is all she needs so that the next time when I interact with her, there is something more to build on there. And you know, we can't heal the problem, but that's what we wanted to. We wanted to fix it. Get in here, we will fix it and then away you go. And now the reality is that there is a process that has to occur. And I think from the two antepartum units where we see these women coming and going, with the education and the change in practice that there are a lot more staff members feeling an awful lot better about what we are able to do for these families as they work through here. We are nowhere near where we would like to be, but there it is certainly a real stepping stone for us, and I think we've come a long way.
>
> So harm reduction initially just became interpreted as, "Oh, that means we don't do anything with these women." And it was like "No, you call abuse when it's abuse." It doesn't mean that you change any of your past practices. It just means that when you look at the problem we might be able to understand that it's not just a substance use that's out of control there – that that may be linked to the fact that this person doesn't have any safe housing or is in an abusive relationship. And if we start moving on those other stressors, that in fact the level of ability to control the substance use may shift. People have not been given the chance to understand that those are connected.

Conclusion: Implications of Treatment Resourcing for Child Protection

In discussing the tremendous need for additional women-centred treatment resources, participants suggested that there was a direct relationship between the nature/number of appropriate treatment options for pregnant/parenting women, and the "demand" for child protection. They further suggested that the availability of alternative treatment options could have significant implications for the child welfare system and could, in effect, dramatically reduce the frequency and degree to which the system intervened:

> I mean, if we had a facility that we could discharge a woman – on methadone or whatever mood-altering substance you are using with her because she is not ready to go to complete abstinence – with her baby, the whole child welfare system would be responding differently to these women.

Part II: Policy Impacts: Aboriginal Women Speak Out

Introduction

Substance use during pregnancy is a very serious issue affecting Aboriginal and non-Aboriginal communities across Canada. In Aboriginal communities, substance use during pregnancy, and the harmful effects of such substance use, are among the multitude of challenges that communities have faced for generations, largely as a result of colonization.

The systematic dismantling of Aboriginal government and culture have left countless people and multiple generations feeling powerless. The residential school system instilled feelings of confusion for the Aboriginal children who attended. Their whole way of life and the source of their cultural pride and self-identity was ridiculed and rejected in an effort to break down their sense of loyalty to their family. The children were brainwashed and forced with physical punishment to reject everything that they had ever believed themselves to be. Generations of children were stolen from their parents and communities. These children were then taught to hate their parents, themselves and their culture. The effects of these teachings have affected the self-esteem and self-confidence of every generation since. When all the children of the village were taken, the parents were left with no children to parent, no pupils to teach, and the children were left with no parents and no one to raise them. The loss of family and culture turned many into lost souls with no purpose or function within the developing society. The horrific abuses that these children experienced left many hollow shells or shells full of rage.

As is the nature of substance use, what started out as occasional use of drugs or alcohol to minimize psychological pain soon turned into a raging epidemic among numerous First Nations people who attended residential schools as well as in all subsequent generations. Although First Nations people have come a long way in reclaiming their birthright, cultural pride and practices, the problems of low self-esteem, feelings of powerlessness and substance dependence are still very much alive.

Ms. G. was a member of a community. She was an Aboriginal woman who suffered from an addiction that did not stop when she became pregnant. She had been involved in the social services system for many years. The services designed to help women recover from addiction issues proved inadequate to meet her needs.

All too often, First Nations voices are not heard within mainstream society, including the media and law-making institutions. In an effort to redress this, the Aboriginal team members of this project went to Aboriginal communities in British Columbia to provide them with an opportunity to voice their opinions and concerns about the issue of mandatory treatment for pregnant women who use substances. A total of 44 people participated in focus groups and interviews. Of these, two were non-First Nations persons and two were men. Thirty-five of the participants were involved in focus groups held on the Gitxsan territory. We felt that First Nations communities have a vested interest in trying to come up with possible solutions to the problems. Through recounting their experience, they can help us decide what types of methods may work and which ones would not.

Why Women May Use Substances During Pregnancy

In discussing the issue of substance use during pregnancy, participants reminded us that it should not be analysed in a vacuum. Most often, drug and alcohol use represents a person's way of attempting to forget about or escape from a variety of painful, co-existing factors:

> There are so many smaller issues that tie into an individual's life. Like, why is the abuse happening? Then you've got all the issues of hopelessness also, whether they're at home, in their own communities, or out there in the larger centres, where they're just lost.
>
> Then you have to look at why the woman is harming her baby. It could stem from child abuse, spousal abuse, or other reasons why they have these drug and alcohol problems.
>
> They turn to alcohol and drugs as a way to ease the problems or lessen them for a little while.

Along these lines, one participant pointed out that because of the complexity of the factors that first lead to a woman's substance use, any type of intervention or approach to support or treatment must be individually tailored:

> It all goes back to if she has no education or no job, if her family abandoned her or if she grew up in that situation – all of these play a part and have to be taken into consideration. And any plan to intervene with the pregnant woman (to prevent her) from drinking or doing drugs, every plan has to be individualized for every woman. They've got different things pushing them into that situation. Because they didn't start doing drugs "just because." They're not still doing them "just because." They have a lot of problems that caused the addiction.

Substance Use as a Learned Behaviour

Participants identified alcohol and drug use as a problem in their community. A great concern was how young children were when they began to experiment with drugs and alcohol, and what their ideas were regarding the reasons for their drug use.

A tragic reality for many First Nations children is their exposure to substance use and violence within their family. This environment very often increases the likelihood that children will begin to use drugs and alcohol in a similar manner to that of their parents and other family members. Children who grow up watching their parents use substances tend to feel powerless to stop or control their situation. Participants spoke about young people modeling their caregivers' behaviour, whether it was positive or negative:

> They see it as normal that this is what happens in all families, when in reality that is really not what happens in a lot of families. So it is really hard to break that cycle. We're starting to see that in some of our young moms. They grew up in that environment....
>
> My son grew up watching us drink all the time. He didn't really know what was going on but he knew that alcohol was involved.

Sadly, participants also reminded us that alcohol and drug use does not have to occur within the immediate family in order for it to be transmitted or to have an influence on future generations:

> I've never seen mom go out and drink, but we were exposed to it in different ways, not in our household but in our friends' households. We've been to other people's households where their parents are, like, partying for three days or something like that. I've seen it a lot of times.

Other participants spoke about the impact of peer pressure. In particular, participants noted how difficult it was to abstain from using substances when one's immediate peer group or broader social circle were using substances:

> Some kids use alcohol just to fit in.
>
> If everyone is drinking around her, it's hard for her to quit.

Impact of Residential Schools and the Apprehension of Children: Loss of Culture and Low Self-Esteem

Several participants spoke of the devastating impact of residential schools on Aboriginal people's self-identity, as well as on their knowledge and practice of their own culture and language. Growing up without a strong sense of culture or with no culture at all can contribute to low self-esteem and feelings of helplessness. Clearly, these feelings are compounded when a person witnesses or experiences physical or sexual abuse – other horrific legacies of residential schools. All of these factors increase the likelihood of an individual using drugs or alcohol or both. Participants emphasized that much of Aboriginal people's destructive and self-destructive behaviour – and in particular their substance use – can be linked to residential schools:

> I went to residential school. I believe that people who didn't go to residential school are more open. At the residential school, they did our thinking for us. They took away our culture, our language, our parents, our guidance. My mom didn't teach me. When I grew up, I followed my mom. I couldn't teach my children. All I could give was my love. That hurt so much – that I lost all that through the silly residential school [crying]. When I left the residential school, I thought I was so smart. Yet at 18 I

> didn't even know I could get pregnant, or that I was pregnant.... We didn't have anyone to teach us. Through residential school, we had no guidance of any kind. So, many of our people thought that alcohol was how to get to know people. That's what I got into. I drank for all of my life except when I was in jail. Alcohol got me into jail – doing stealing, murder, whatever.... The people who are in jail are mostly from residential school.

First Nations people also clearly expressed that keeping children in their cultural environment is very important:

> I think also that, further down the line, when that [child] reaches young adulthood, that history could be very distressing to self-esteem as well. We see a lot of that with films, with the abduction of children into foster care and into non-native homes. You see the destructiveness that is done to individuals. That's led to a fair amount of alcohol and drug abuse right there, is that past knowledge.
>
> The white man took my kids away – all my kids. I could give them love, but not change their diapers. I think they should be brought up in traditional homes.

Impact of Childhood Physical and Sexual Abuse

Several participants also spoke about their use of alcohol and drugs as a coping mechanism, a self-administered narcotic to numb or dull the pain of sexual and/or physical abuse:

> If you're a victim of sex abuse, you use alcohol to cope.
>
> I was sexually abused as child and grew up with drugs and alcohol in the family. I had to put up with family fights and child abuse. I was a teenage mother and I drank through my first three pregnancies...and with my last two kids I learned the effects of alcohol and I didn't. I lived with the effects of being sexually abused.

As is suggested here, substance use during pregnancy may be especially likely if a woman "grew up with drugs and alcohol" and if the negative effects of substance use on fetal development aren't fully appreciated.

Lack of Knowledge About Harmful Effects of Substance Use During Pregnancy

Several participants shared with us that they had used substances during pregnancy out of ignorance; at the time of their pregnancy, they did not know of their potential harmful effects:

> If I had known more, I wouldn't have put her at risk.
>
> I think it's so wonderful that there are nurses and educated people who could go into the schools now and teach the kids and empower them.... We walked into everything without knowing anything.

Participants also suggested that young people in many Aboriginal communities continue to lack knowledge about the impact of substance use on fetal development. Participants felt strongly that education regarding pregnancy, sexuality and birth control, health and hygiene, and substance use was crucial, and needed to be openly available and accessible in schools and in other community-based meeting places.

Substance Use in Unwanted Pregnancies

Several participants spoke of some Aboriginal women's reality: of being substance-dependent or addicted, of having an unwanted pregnancy, of feeling that abortion is not a legitimate or viable option, of not knowing what to do and, therefore, consciously or not continuing to use substances as a means to terminate the pregnancy. As these two participants told us:

> Some women...find out they're pregnant and they don't want to be pregnant. They'll abuse themselves any which way they can...trying to kill the baby. They'll take anything.
>
> In some cases [substance use] could be because the mother doesn't want the child and doesn't know how to handle the situation. She doesn't know what to do. She's looking for a way out even though she's harming herself as well as the baby.

Through these comments, participants reminded us that, despite the legality of abortion in Canada, it cannot be assumed that abortion is a real choice for many women, especially those who are young and poor. In some Aboriginal communities, there is considerable social/cultural opposition to abortion; therefore, a woman would need to have an exceptional reason to seek and obtain an abortion. A pregnant woman's ongoing use of substances might be viewed as such a reason, and thus in some cases, substance use during pregnancy may be seen as an abortion-enabling strategy.

The Power of Substance Addiction

Finally, in speaking about why some women use substances during pregnancy, some participants spoke about the overwhelming and all-consuming nature of substance addiction:

> Speaking as someone who has experience, I've had two children and my youngest daughter turned out very intelligent, thank God. I did not consume alcohol while I was pregnant with her, but at the time that I did become pregnant with her I was an alcoholic, and I was addicted to marijuana. I was able to give up the alcohol easy enough, but to give up the marijuana right away was not easy at all. I think I didn't stop completely using marijuana until I was in my fifth or sixth month of pregnancy, but I did it. I did not let other people know that I was using drugs; I would hide it. It is extremely difficult to refrain yourself from it when you are addicted. It's easy enough to say, "Well, I won't do that if I ever become pregnant," but it's not so easy when you're going through it.
>
> The best thing that could have happened to me was getting the infection and going into hospital. Without that I'd still be out there. Addiction is so powerful. It took over

> my life. I put it before my children, my family – everything. It took me getting sick.... I couldn't get dope because I couldn't move. The addiction affected my mind so much. I'd do anything to get drugs....
>
> I was addicted to cigarettes with my son. You know, you just can't quit. You want to but it's hard.... You love them and they are special, you don't want to have to do it!

Addictive substances, from cigarettes to marijuana to alcohol to heroin, can so alter a person's brain chemistry and impair her thinking ability, that despite her every intent to reduce or abstain, it is extremely difficult to become and stay clean.

Barriers to Aboriginal Women's Treatment and Recovery

Structural/Institutional Barriers

Many participants believed that a major barrier to the effectiveness of programs and services was that the federal and provincial governments do not recognize hereditary systems and teachings. This means, among other things, that decisions regarding program funding are guided by mainstream criteria, which may not recognize the value and validity of Aboriginal approaches. Consequently, many hereditary or traditional approaches are under-resourced or have no resources at all:

> The other big area that I see might be useful for us is having a building controlled by the people themselves. Not having to meet other people's standards – "You can't do that!" or "You're not doing it right!" Basically, trying to meet other people's standards versus how we, as First Nations, deal with it. That is a major area that blocks us. It might be easier for us to say to a young mom, and use the family members or house system to say, "You're pregnant and have support."
>
> Right now it's the government's way, where they don't recognize us as Gitxsan women. We're just put under the same umbrella. There's no sense of identity there.
>
> But the process is so slow as it is now, lacking for services. And it all comes down to the almighty dollar to getting these programs done. There's so many restrictions.

Lack of Fit Between Existing Resources and Women's Needs

Participants noted the importance of ensuring that a treatment approach and/or facility was truly geared to Aboriginal women's needs. The level or success of the healing process depends on the quality and appropriateness of the support that an individual receives as well as the care provided by the service workers. Among the ways that resources can demonstrate their responsiveness is through the language used (e.g., to talk with and about "clients," "helpers," etc.). As one participant told us:

> Just the word "counsellor" scares a lot of people off. It scared me off, my husband... Make it more like Big Brothers or Big Sisters, something like that. Make it inviting – something so that young mothers/women would feel welcomed.

Participants also spoke strongly about the need for support people to be encouraging and to provide guidance without being "preachy" or punitive. Treatment programs that were not geared to women's needs could be "destructive" rather than effective:

> Some centres are very good and some are very lacking in their own way [in terms of] how to deal with individuals who come to the centres. It can be more destructive because I have come across a couple [of] centres that are very surprising.... And if you don't have proper counsellors within that Ministry system, unfortunately it's a very destructive force there.
>
> One way that will not help is to preach to them about "You shouldn't do this!" That will just push them away!

Unsupportive Attitudes of Treatment Practitioners and of Society in General: Blaming and Shaming

Several participants identified dominant, negative attitudes toward substance-using pregnant women as a barrier to women's help-seeking and recovery processes. Participants noted that many women likely were afraid to access services and support as a result of their fear of being blamed and rejected – "thrown away" – by authority figures, helping professionals and community members in general:

> Make it easier for mothers to come forward and seek advice and counselling without ridicule or condemnation. I'm sure that a lot of women out there want to seek help but they're afraid to do so. Afraid that they are going to be judged...or talked about.
>
> I think it needs to be more of an open issue. People need to hear that it matters.... It needs to be widely broadcast. It's a severe issue. Like the Body Shop. They have T-shirts that talk about the issue of violence against women; why not one about substance use during pregnancy?

According to focus group participants, another facet of professionals' prejudice was their racism. For example, one Aboriginal woman felt that her physician accused her of abusing her infant because of the doctor's prejudicial beliefs about Native, substance-using women; the doctor was not aware of a particular type of physical occurrence in some Aboriginal infants, and instead was quick to label the markings as signs of abuse:

> My doctor said I was abusing my baby because of Mongolian spots. She said there were marks on his back that looked like abuse. But if you're Aboriginal or Asian, you know that they're just Mongolian spots, and that the spots go away.

Participants suggested that training efforts for human service practitioners needed to highlight the root causes of women's substance use, and needed to emphasize the interconnectedness of a woman and her fetus, and approach them wholistically:

> I also think there needs to be more training or education for the counsellors in regards to this topic as well. Like, it's fine and dandy that people sit around and talk about it

> and judge the situation, but people really need to understand 'cause it's a broad spectrum of a lot of different issues. It's not the just the mother; it goes beyond that. There are many different reasons why this is happening, and counsellors really need to be aware of that.

Insufficient Services and Resources

Participants emphasized that there simply were not sufficient resources and facilities to meet people's needs and demands for services. Consequently, people seeking and needing services were not being served. Moreover, front-line workers were overtaxed and in danger of burning out:

> Just mental health of the front-line workers. You're here to do a job, sure, but you work two or three other jobs and that's something that with more advanced training for front-line workers as well too. Trying to find additional time and schedule and dollars to take that additional training.
>
> But it's also dealing with our medical staff within the region as well, too.... There's a lot of problems there with the hospitals.... There's a lot of areas that still need a lot of work. We all ha[ve] the same issues. We're lacking in services.

Aboriginal Perspectives on Mandatory Treatment/Confinement for Pregnant Women Who Use Substances

In all of the focus group discussions with Aboriginal women, participants were asked to share their opinions about mandatory treatment and confinement for women who use substances during pregnancy. We were struck by several facets of these discussions. First, it appeared that despite the tremendous importance of this issue for Aboriginal people, participants had taken or had been offered few if any opportunities to openly discuss their views. To a large extent, it seemed as though this topic had been avoided in communities, even though it became evident that nearly all the participants had been personally touched by the issues in some way. Participants were also divided and conflicted about mandatory treatment/confinement. Discussions revealed the complexity and interconnectedness of the issues. In addition, we observed that the process of discussing and debating the issues seemed to influence and in many cases alter people's opinions. In particular, a number of participants who initially expressed their strong support for mandatory treatment/confinement came to rethink and question this support, especially as they mapped out the potential implications of mandatory treatment in relation to the historic and current oppression of Aboriginal people.

In the following section, we discuss the primary themes arising from our discussion of mandatory treatment/confinement. We conclude by sharing excerpts of one particularly powerful focus group discussion, in which, through the process of dialogue and reflection, several participants came to a new understanding of the implications of mandatory treatment for women who use substances during pregnancy.

Distinguishing Between Mandatory Treatment and Mandatory Confinement

As several participants pointed out, it is important to distinguish between mandatory treatment and mandatory confinement. Mandatory treatment was seen to be of little value. A woman who was not interested in treatment would not benefit from treatment and "would just rebel if forced into treatment." Instead, efforts needed to focus on understanding why women use substances, why they are unable or unwilling to reduce their substance use or abstain, why they are refusing treatment, and what they need for healing and recovery.

Multiple Perspectives – Divided Opinions

As noted above, participants held diverse views about mandatory treatment. Aboriginal women clearly are divided in their opinions. Many participants spoke of the complexity of the issue, especially in light of Aboriginal culture, traditions and experiences of oppression with non-Aboriginal systems. The decision had significant ramifications for women, children and community members, regardless of which direction was taken. A number of participants also held multiple and perhaps contradictory beliefs in relation to mandatory treatment. For example, some participants indicated that they would condone mandatory confinement for a member of their own family in order to prevent fetal harm, while at the same time, they opposed mandatory confinement because it violated women's rights:

> I have mixed feelings about this issue. On one respect I agree, if it was my family member I wouldn't want [her] to harm the fetus. On the other hand it would also depend on the woman. If she didn't want the treatment, I would not support confining that woman against her own will. I do feel that an effort should be made to try and reach out to them to find out why they can't stop or just to encourage treatment. But, as far as forcing them into treatment, I would not agree with that.

Many participants indicated that it was very difficult to decide on mandatory confinement given that the issue involved the infringement of one individual's rights in order to protect another. Participants' deep ambivalence is reflected in these comments:

> It's a tough issue. It's hard to really decide which side you should go for. One has to think about the unborn child. They don't choose to come into this world and they're the ones who ultimately suffer the consequences.... Looking on the other side, I would be outraged and angry about being mandatorily confined. I would feel violated. Which is why it's a touchy topic. You're for both sides.
>
> I don't think it's fair to the child to be affected forever. They didn't ask to be born. They didn't ask to be born handicapped, so it's a really emotional thing. It's a very fine line. My overall conclusion would be that it's a case-by-case basis. In some instances I might feel that yes, this person should be confined; other instances, maybe not. It's hard to say.

In Support of Mandatory Confinement

Many participants were supportive of mandatory confinement, in that they saw it as a means to ensure that women took responsibility and were held accountable for their behaviour. Participants spoke of mandatory confinement as an action or option of last resort, but nevertheless an action that needed to be taken, given that communities ultimately become responsible for caring for a substance-affected child:

> If two people are fighting they could be charged with abuse, whereas a woman who abuses her fetus.... I believe there should be some law of abuse...she's got to be held responsible for that. And then who suffers the outcome? The child, the community and the people looking after [him] later. If he is brain-damaged from the alcohol...and the mother's off scot-free somewhere. I really disagree with that...
>
> If someone's pregnant there should be mandatory testing. If you're pregnant there are some tests we have to do. Like the prenatal stuff. It should be included there. That way the doctor knows, "Okay, she uses drugs." Then they can say, "Okay, there's a treatment centre. I suggest you go." Of her own free will, but if not, she'd still have to go. Like I said, the community suffers from the irresponsibility of the expectant mother.
>
> I don't know – in my heart I feel that the best choice would be the rights of the child. The mother should have rights, but once there's a pregnancy the rights of the baby should come first. The baby has no one to speak for them. They're the ones who really suffer after they're born and through their life. It's everybody's problem. It's a society thing. It won't be just the mother's problem.

Participants favouring mandatory confinement also spoke of it as a possible deterrent for some substance-using pregnant women.

> ...some kind of policy. I know that I wouldn't have done it if there was a law.

In voicing their support of mandatory confinement as a last resort, numerous participants shared that they had first-hand experience with these issues within their families. For some participants who were involved in raising or supporting people affected by fetal alcohol problems, the merits of mandatory confinement were being considered in the interests of strengthening First Nations communities:

> I believe that the woman should be educated, given a choice, and if all else fails then confine her. But that would be a last resort because it's cold in there. There's no feeling in a jail house. I know of a young man who feels that he can't trust anyone and he's always in trouble. Like he's addicted to trouble. And I'm the one who has to face it. And where is his mother? She's under the ground from drinking and drugging, and she's left a beautiful boy behind who's not normal. Like, he's normal in every sense but he's angry and affected by the drugs his mom did when he was in her. He's my grandson....

> My niece has quite a few children, and I've seen results of her children. It hurts to see them in a situation that could have been prevented. She's pregnant again but she's not doing that. It's important for our Nations to be strong. Maybe we have to start infringing on people's rights.

Mandatory Confinement within an Aboriginal Context

Through their discussion, some participants made it clear that they were supportive of mandatory confinement, but only as it would be practised within an Aboriginal context. Among the key features of such a context was the notion that the family was responsible for looking after all of its members:

> In my mind, if you were the First Nations writing the law for your Band about this issue, you'd set up a process so that you would have the family responsible for all Band members, and if that fails then you would seek the advice of chiefs and council, and if the process failed you'd have to take it case by case. There would be too many exceptions or differences, so in that case we would have to set up principles or processes. So that in a situation like that you'd follow through and set up this process, and in that situation you could go and try and apply the process to the people. But if it didn't work, then there would be that space in the process that would allow you to look at the different situations that apply to different people. So, you would be able to look at it case by case.

Another crucial aspect of an Aboriginal context is the notion that although a woman may be confined, she is still very much part of the community; she is not rejected or cast away in the interest of protecting the fetus. This also means that a woman's confinement/treatment largely involves efforts to (re)instill in her a sense of self-respect, and to (re)connect her with the traditional teachings of community elders. As one participant put it:

> I believe in the power of kick-butt grandmothers. If we had a circle of women here, and if there would be a pregnant woman in the circle, and she's defiant...what's wrong with my taking her to M's house?… I don't want to harm anyone, but I believe that those grandmothers need to step in and take those women. After the baby is born, they can do what they want. I believe in women elders. I like seeing them kick butt.…

In Opposition: Mandatory Treatment/Confinement as a Means to Further Oppress Aboriginal People

A number of participants were strongly opposed to mandatory confinement for treatment because they viewed it as a means to further oppress Aboriginal people. Participants noted that, if mandatory confinement were to be enacted via mainstream legislation or policy, Aboriginal people would likely be disproportionately represented among those confined, just as they are over-represented in the justice and child welfare systems. Participants voiced concern about who would have the authority to decide whether mandatory treatment was "appropriate," how these decisions would be made, and what safeguards would be in place to ensure there was adequate due process measures. As these participants noted:

> Our people have been oppressed for so long. If it was mandatory…if you're born Aboriginal, you're born political.... It seems like the basis of our health issues stem from Geoffrey Amherst forcing alcohol into our people in the 1700s. You can imagine how deep it's been. You have to weigh both sides. For social justice, the better method is to educate our young people from the start about the long-term effects of FAS. You have to think in terms of the seventh generation. Each of us takes our personal cycle; we're the start of the intervention. We need to get rid of the oppressive policies of the *Indian Act*. As for my first reaction – to make treatment mandatory – to me that's now a band-aid change. They wanted us to assimilate so they forced certain things on us. If they keep forcing, we'll never de-colonize. We'll always have the "we have to have the higher-ups' permission" mentality.
>
> With the question of mandatory treatment, for me...I sort of half and half think it should be mandatory. But I've been under a life of mandatory treatment since I left residential school, in jails, and I didn't like it. Still...I'm undecided. I don't like people to boss me around. I like to be educated and to know why I'm doing something.
>
> The doctors and everybody, they discriminate against you because you're a woman, they discriminate against you because you're First Nations, they discriminate against you if you live in poverty.... So, you've got a lot of shots against you already.... You'd be abused from all directions.

Similarly, another participant felt that First Nations women would be a primary "target" of mainstream authorities' implementation of mandatory confinement:

> I was wondering what actions the government was going to take in finding these women who had problems, because it's so easy to hide your problems if you're a drug addict, or abusing alcohol even. How are they going to find out who the target people are? Are they going to have mandatory drug testing on the street? I think the target group would be Natives between the ages of 14 to whatever. That's what I've been thinking.

Other participants questioned how mechanisms to enforce mandatory treatment would interface with already complex jurisdictional issues. Implicit here again is the notion that mandatory treatment/confinement may be a means to undermine Aboriginal autonomy:

> So, [when] we're talking about this issue of mandatory confinement, is that federal? So, can they come onto the reserve without the permission of chief and council?

Mandatory Treatment/Confinement as Potentially Harmful to the Fetus

In deliberating about mandatory treatment, several participants spoke of its potentially negative consequences, including the possibility that a pregnant woman would become resentful of her fetus, and in turn the baby would be ultimately harmed by this resentment:

> Mandatory treatment into a centre can be more destructive to the individual, with the rebellion and the barriers that that the individual is going to put up. And the info's not going to get through to the woman if these barriers are up. There's that resentment, and these feelings are carried right down to the fetus. The emotional factor is harmful to the child, whether that child will come out even more colicky because of the hate and resentment and the hormones and adrenaline that run through the mother's body as well. The emotional tie is very important to the fetus's development, and this emotional strain on the mother through mandatory treatment could be just as harmful to the fetus.

Other participants emphasized that the fear of confinement might drive many women underground, thereby avoiding prenatal care, or that women might be driven to have abortions:

> If they had mandatory treatment, how many women would admit it? They should at least go halfway and help the woman to want it.
>
> It shouldn't be for a whole nine months. If we did that there probably would be more abortions. They won't see doctors and keep their pregnancy a secret.

Finally, other participants were opposed to mandatory treatment because they believed that community-based approaches would be better able to address the issues:

> I personally do not [agree with mandatory treatment]. There must be other ways that can be put into action with the proper support from the community and community workers. That there be a community effort to try and find alternative solutions other than mandatory treatment that would be more constructive for the individual.

Key Excerpts from One Focus Group Discussion on Mandatory Treatment/Confinement

> A woman who abuses her baby – unborn fetus – I believe there should be some law of abuse. You know, she's got to be held responsible for that [because] who suffers the outcome? The child, the community and the people looking after [him] later. If he is brain-damaged from the alcohol, and the mother's off scot-free somewhere – I really disagree with that. With my upbringing I was taught that women are being given a gift to be able to have a child.
>
> It would probably be a lot more effective for me to hear it from someone who has been through it and actually experienced it.... And, if you've been there, it's easier for you to relate to that woman and accept her.
>
> The doctors should have more control. If someone's pregnant there should be mandatory testing: "Okay, if you're pregnant there are some tests we have to do." Like the prenatal stuff – it should be included there. That way the doctor knows, "Okay, she uses drugs." Then they can say, "Okay, there's a treatment centre. I

suggest you go." Of her own free will, but if not, she'd still have to go. Like I said, the community suffers from the irresponsibility of the expectant mother.

But a lot of times she's the victim too! Maybe she's been raped when she's on some kind of drug, so you've gotta kind of balance that out a bit. She's been hurt once already. Now the doctor's telling her what to do, she's a victim again.

The doctors and everybody, because you're a woman they discriminate against you, because you're First Nations they discriminate against you. If you live in poverty, there again, they discriminate against you. So you've got a lot of shots against you already. That's really tough. You'd be abused from all directions.

I'm kind of having second thoughts about the doctor's input there. Or their authority. They're given too much say sometimes.

I think that if there was mandatory treatment in place, and if the young mom's pregnant, I think there would be a lot less babies that would be born affected by alcohol....

Talking to her and trying to get her to understand over the duration of her pregnancy, she'll learn to be more responsible to herself, her body and her baby. And who knows, maybe it will help her in the long run to help her take care of her baby. There are so many young women who use when they're pregnant, have the baby and then just give them up for adoption. Whereas if there was mandatory treatment, during the duration of their stay, they may learn life skills.

I don't think a medical setting would be very good. [It should be more]...like a home environment!

One concern I just thought about just now: where does the guy fit in here? Of course, guys can't have kids. So again, it's telling the women, "Okay, you have to go," and we're starting to slide back. What about equal rights? You have to look at how many aspects there are to the problem here.

Like I said, male doctors – telling me what to do again. It seems like it would be going back to the old ways again.

I don't think it should be one doctor, I think it should be maybe a couple...not just one person. And I think rather than just saying [that] the woman, the pregnant woman, goes [for mandatory treatment], who got her pregnant? We need to make the men more responsible because they are responsible too, and they're getting away with a lot!

A young woman who is forced to go, I don't think it will work because then she will just get angry. She'll rebel, she won't do nothing....

> I agree with you that individuals who are forced into treatment – because a big percentage of them don't follow through. You know, once they're out they'll continue using again. You haven't really fixed the problem.
>
> And using smoking to a teenager by telling them don't smoke...don't do this, don't do that. What do they do? They rebel! "Oh, I'll smoke." Okay, then, you're telling a grown woman, "Don't do this, don't do this." Nine times out of 10, she'll rebel.... So, comparing kids and their smoking to the older women and their drugs – because a lot of us are really young at heart. Our being young parents, we still haven't matured ourselves, you know.... You could find more comparisons there in what works for the kids and their smoking, and what will work with the women.
>
> I'm worried about the kid, but how do we get around that? That is a big barrier to a lot of women seeking help... The women are abusing themselves and the baby just happens to be there. They don't feel like they are worthy of nurturing love. I think they need to learn to love themselves. First, my baby wasn't here. First, I was. I've got to learn to love myself. That baby is a part of me.

As is evident in these excerpts, this forum provided Aboriginal women with an opportunity to reflect upon the possible implications of mandatory treatment. Initially, women were depicted as deliberately "abusing" their fetus; yet, as the discussion unfolded, participants reframed the situation as one of a woman's self-hatred, with the fetus unfortunately being affected through the woman's self-abuse. In addition, at the beginning of the discussion, the child's needs were pitted against and put before the needs of the mother. Through the discussion of the history and circumstances of the woman's life, however, participants identified that if the problem were to be effectively addressed, the needs of the mother had to be met. Participants recognized that many women in these situations are themselves young at heart and needed to be seen as worthy of nurturing and support. Confining a woman against her will was viewed as being more damaging than helpful. Finally, participants came to appreciate that abuse of power is endemic in our society: by police officers, social workers, doctors, nurses and even judges. Mandatory treatment could provide yet another vehicle for such abuse of power.

CHAPTER 5: CASE STUDY: AN ABORIGINAL NATION'S EFFORTS TO ADDRESS SUBSTANCE USE DURING PREGNANCY

By Audrey Lundquist and Suzanne Jackson

Part I

Background

Purpose of the Case Study and Research Questions

This chapter outlines the efforts of one Aboriginal[1] nation to deal with the issue of substance use during pregnancy. The chapter also explores the substantial barriers that face Aboriginal communities in Canada, barriers that have been created by a long history of policies from many levels of government that often conflict with one another and destroy the capacity of Aboriginal people to shape their own destiny.

The chapter focuses on three central questions:

1. How do the Gitxsan people directly or indirectly address the issue of pregnant women who use substances?
2. What do the Gitxsan people think of present efforts taking place in their community concerning pregnancy and substance use, and what are their ideas for improvement and change?
3. Do the Gitxsan people think that mandatory treatment for pregnant women who use substances is an appropriate response to the issue? Why? How would it be implemented? If not, why?

The Researchers

We are Gitxsan women who have personal knowledge of the Gitxsan culture and the aspirations of the people, and are connected to our Nation and its communities. As such, we have a vested interest in the outcome of the research findings. We share particular beliefs about substance use, addictions, treatment and our culture, including:

- There is a distinction between substance use and addiction. For many, substance use is temporary, an individual response to particular stresses or a whole community way of life in which substance use is normalized. Once circumstances change with the person and/or the community, substance-use can stop with support. Not everyone who has a substance-use problem will become an addict; in fact, some will use substances all their lives and never become addicts. The defining characteristic of addiction is compulsion. Once a person becomes addicted, they have to deal with a long-term and baffling problem.
- The issue of pregnant women who use substances or who are addicted must be dealt with by the community. Some communities are resource-rich and some are poor, and this will affect how they can tackle the issues.

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[1] The term "Aboriginal" refers to all indigenous people in Canada, which include Intuit, Metis and First Nations people. Each group has a distinct culture and a unique relationship with Canada.

- The Gitxsan people and the communities in which they live have the opportunity to meaningfully participate in the processes that shape their future.
- The Gitxsan people have the expertise to create the kind of change that will promote the social cohesion and ultimately the well-being of Gitxsan people. The expertise includes but is not limited to cultural knowledge, the traditional roles (particularly the role of women), youth perspective and involvement, program development and management, community development and personal knowledge of oppression by the society at large and by their own communities.
- The Gitxsan people intend to eventually replace the Band Council system of governance with the traditional system of governance. This transition process will be strategically managed for empowerment.
- The Gitxsan people will eventually have control of the resources on their traditional territory to create the comprehensive change envisioned.
- That many Aboriginal communities are engaging in similar changes in their communities.

The Reasons for the Case Study

Prior to joining the research team, we had followed closely the case of the Winnipeg Child and Family Services (WCFS) v. Ms. G. case. Ms. G. was then a 22-year-old First Nations woman who was pregnant with her fourth child and addicted to sniffing glue. Her other three children were not in her care. WCFS sought and received a court order to detain Ms. G. in a treatment centre to prevent her from using substances during her pregnancy. The Manitoba Court of Appeal reversed this order and the case went to the Supreme Court of Canada. On October 31, 1997, the Supreme Court of Canada released its decision, with the Majority opinion stating that the issue of mandatory treatment for pregnant women who use substances is an issue for law-makers and communities, and not for the courts to decide. Thus, mandatory treatment as an approach to dealing with pregnant women and substance use was launched for public debate.

We were apprehensive because we knew that any policies concerning mandatory treatment would have a huge impact on Aboriginal women, their families and communities, and yet they would likely have little input into the development of these policies. We worried about how Ms. G. had been portrayed in the media. Although little was actually discussed about her individual life and the circumstances leading to her situation, she was generally portrayed as a selfish woman unable to give up an unhealthy lifestyle for the good of her children. When we were asked to join this project a few weeks after the Supreme Court decision, it seemed like an ideal opportunity to make sure that Aboriginal voices joined those of the legal community, the civil rights community, the feminist community, and many others that were debating this issue. We also wanted to make connections with other Aboriginal researchers so that our efforts could support one another and networks could be established.

Drug and alcohol use and addiction have been compelling issues in Aboriginal communities for a long time. It is understood as an individual lifestyle choice that has become out of control. Yet in some communities, alcohol and drug use is a way of life for most residents. Communities subsumed by substance use and addictions is the result of marginalization and destruction of family and culture.

Aboriginal people are continually punished for their addictions, more so than others, and are over-represented in the criminal justice and child welfare systems. These punitive responses often result in further dependence upon substances. The individual, family, culture and community are not healed. It is a vicious circle.

The experience of addicted Aboriginal women who become pregnant is also different from the experiences of other women in this situation. An Aboriginal woman's present reality is shaped by what she carries on her back. She hauls not only the legacy of colonialism, racism, marginalization and historic oppression but also the sexism apparent in her own community and the larger world around her. In the end, she is seen by others and often herself as "the lowest of the low," less worthy than others, even than other addicts, and even than other women addicts.

We also believe that this is a crucial time for Canadians to learn about Aboriginal people and their way of life, to value it, and to work with Aboriginal people to change the way we all live together and with our earth. To many Aboriginal women, things seem completely hopeless. But every once in a while in our collective history, we get a glimpse of hope that things could be different, at least for our children and grandchildren. *The Royal Commission on Aboriginal Peoples (RCAP)* report gives us such hope. It creates a conceptual framework for understanding where we are in our political history and says in a louder voice than any past reports that the human condition of Aboriginal people in Canada is worse than the conditions of other marginalized groups. This suggests that equality for Aboriginal people is still a myth.

There are other reasons for hope. The *Canadian Constitution Act*, Section 35, recognizes our Aboriginal rights. The Delgamuukw v. British Columbia decision made by the Supreme Court of Canada on December 11, 1997 (SCC 1997 Vol. 3) recognizes that First Nations' claims to the land have never been extinguished and thus the legal foundation is set for land claims in British Columbia. We are also encouraged by the Healing Movement in which Aboriginal individuals and communities are learning about the impact of colonization on individual behaviour and nation-building, finding out that our behaviour is a natural response to marginalization and oppression, and using this understanding to recover. The self-determination movement will not be stopped. It is an idea whose time has come.

It is important that every Aboriginal woman has the opportunity to claim her rightful place in these processes toward self-determination. Her issues and her needs as she defines them must be part of the agenda.

Although there are reasons for optimism, there is also a backlash to the progress that First Nations people are making. One only needs to listen to the rhetoric of resistance to the concept of Aboriginal rights and the resistance to democratic tools that are used to try to achieve social justice for Aboriginal people to get a sense of societal attitudes. One current example is the Nisga'a treaty process in British Columbia. The Nisga'a treaty was negotiated by duly elected officials who represent the interests of all British Columbians, yet several political parties and powerful interest groups are calling for a referendum with the hopes of defeating the treaty. In September 1998, David Black, owner of more than 80 community newspapers in three separate chains in British Columbia, Alberta and Washington State, instructed editors of the papers to write and print only editorials arguing against the Nisga'a Treaty. This attitude suggests that the RCAP report and other such documents are not considered credible sources of information and enlightenment to many British Columbians. More importantly, this unsympathetic attitude is a major barrier to addressing the complex multi-dimensional issues that Aboriginal people are trying to grapple with. Addiction is just one issue.

Not only do First Nations people face barriers to gaining control of their land and resources, they also face misunderstanding about the importance of cultural renewal. Some in mainstream society view Aboriginal culture as customs, art, dancing, language and food. While all of these are crucial symbols of the culture, they are not its essence. Aboriginal culture is a world view, shaping the way people see themselves in relation to others, to their past and future and to their place among all living things. Aboriginal people are expected to hold the values and beliefs of mainstream society, and to operate within these or they are not considered successful or competent. And yet by doing this, they give up or struggle to hold the very values and practices that make them feel human and competent. There needs to be a shift in attitude whereby mainstream society values Aboriginal beliefs as equal to mainstream ones. There also needs to recognition of the fact that the cultural renewal movement is recent, and Aboriginal people are re-defining themselves. This process needs to be supported and respected.

A recent federal report on the Canada 2005 project says that the mood of Canadians is hardening. The report said that "Forty percent of Canadians surveyed believe Aboriginal peoples have themselves to blame for their problems." This belief has a powerful impact on what Aboriginal people can realistically do to resolve the horrific problems that resulted from colonialism and oppression. These societal attitudes act as powerful invisible barriers to accessing much-needed resources.

There are other reasons why this research is important at this particular time. At a recent press conference in British Columbia, the Honourable Lois Boone, Minister for Children and Families, announced the public release of the Community Action Guide for the Prevention of Fetal Alcohol Syndrome (FAS). Figures released at that meeting indicated that there are approximately 45,000 babies born in British Columbia every year and of these, anywhere from 80 to 800 babies are affected by substances. Although it is not known how many pregnant women are engaged in high-risk drinking and substance use, Aboriginal women are likely over-represented in this population. Most importantly, at this time in our history, the Aboriginal population is young and is entering or in childbearing years. According to the 1991 Canadian Census and the Aboriginal Peoples Survey:

> …of the 170,000 Aboriginal people in the province, over 35 percent are under 15 years of age, compared to 19 percent of the non-Aboriginal population. Fifty-seven percent of Aboriginal people in B.C. are under 24 years of age. The Aboriginal youth population is the fastest growing demographic group in the province. This is the reverse of the elderly population. Aboriginals 55 years of age and over constitute only 7 percent of BC's Aboriginal population while non-Aboriginal people over the age of

> 55 account for almost 23 percent of the non-Aboriginal population (www.anf.gov.bc.ca/aaf/faqs/faqs.htm.)

Finally, we contend that this research is important because some Canadians seem unable to learn a few important and simple facts. Most people are better able to change dangerous or unhealthy behaviour if they are given support and tools at the earliest possible age rather than waiting until their behaviour is so entrenched that it requires punishment and surveillance by others. We also seem unable to act on the irrefutable knowledge that problems such as addictions are connected to broad life circumstances as much or more than individual ones. We fear that unless there is a change in our thinking, substance use among pregnant women will join the many issues that have been defined as individual problems and treated in a punishing fashion in isolation from social and historical circumstances.

The Research Approach

When the research process began, we were invited to present the project to Gitxsan women at the Women and Wellness Conference held in the village of Gitanmaax near the town of Hazelton in northern British Columbia. We had the opportunity to speak informally to front-line workers and local residents to determine if there was an interest in participating in the research, and to distribute questionnaires soliciting views on mandatory treatment. We received a very positive response to the idea of the research, although not many questionnaires were returned.

We held a focus group at the conference to discuss the issue of mandatory treatment for pregnant women who used substances. It was during the focus group that we became aware of the possibilities of this research and that it could create a powerful process for action. During that meeting, many participants who had not had the opportunity to consider the issue before joined in vigorously to the discussion, supporting and challenging each other, sharing experiences and changing their views. We decided that a research approach that provided opportunities for women to come together on this issue would be the most effective and perhaps begin a process of change.

We also decided that it would be useful to focus our efforts on one Nation and its communities so that interested women and others could have an impact on the local policies there. Selecting our own Nation made most sense to us. We had begun there and people were interested. We knew the people and they knew us. There was an existing level of trust.

In summer 1998, we went to six Gitxsan communities to gather data. We interviewed several front-line workers, program managers and board members responsible for health and social programs in four of the six communities. (Appointments were set up with front-line workers in each community but for one reason or another, two appointments were cancelled.) We also conducted several focus groups with an average of five to six participants, largely First Nations women. One group had more than 15 participants. Although there were relatively few men and non-Aboriginal women who participated, their views were insightful and welcomed.

Each interview and focus group was one to two hours long, and all were recorded in writing and audio taped. At the outset, the participants were told about the study and its aims. We made it clear that their participation was voluntary and that we would not identify them in our report. We could not guarantee confidentiality in the group but participants agreed to keep to themselves what they learned in the group.

In writing this report, we are conscious of our commitment to maintain confidentiality. We have not used many direct quotations because, in a small community, it is easy to recognize the words of others. Two sections of this report deal with First Nations' opinions: one has been written to express the opinions of First Nations women living both on and off the reserve, and this chapter aims to portray the experiences of Gitxsan people living on-reserve. In this chapter, we have occasionally added a quotation from a person who did not live in a Gitxsan community but who was a member of another focus group. We have done this only when the person speaking expressed an idea that was widely held by members of the Gitxsan communities.

The tapes and notes were reviewed and the data were categorized into themes and sub-themes. Issues that cannot be dealt with in this report are flagged as potential research issues at the end of the report.

We have only begun the research process in these communities but we feel confidant that the data were sufficiently rich to support preliminary findings that could be used as the basis for ongoing community-based, participatory action research. The researchers felt that at the very least the voices of the participants would contribute to the debate about whether or not mandatory treatment of pregnant women who use substances is an appropriate response. This issue is dealt with largely in Chapter 4.

Part II

The Case Study

This case study takes a broad political and legal perspective, and examines individual and community issues. This approach was taken because of the firm belief of the researchers that the issue of pregnant women and addictions must be dealt with in the context of the aspirations of First Nations people to heal themselves and their communities, to be self-determining and to reclaim their culture.

We used three frameworks in analysing our data. The first was modeled on one developed for dispute resolution. Early in our research process, the research team met with Stephen Owen, former Ombudsman of British Columbia and presently head of a graduate degree program in dispute resolution at the University of Victoria. One of us on the First Nations team had already studied with Professor Owen. It seemed appropriate to use this framework because the issue of substance use during pregnancy has been formulated as a dispute, and policies that bridge different perspectives will have the most likely chance of success. This framework includes such categories as issues, parties, context and government policy. This model also includes an inclusive process for involvement in the policy process.

We also examined the data from the perspective of two world views. We live and work in two worlds: one of mainstream culture and one of our own culture. It is not easy to describe living in two worlds, one where we do not necessarily belong although we are apparently present in it every day, and one where we feel at home, where we exist even though it is not present to those around us. These worlds hold separate ideologies about living, and often these ideologies are enmeshed or conflict with one another. Often during the process of analysing the data, we felt that we were analysing data through bifocal lenses. At times, the enmeshment blurred our vision.

We know that policies that have the most chance of success for Gitxsan women, Gitxsan people and other Aboriginal peoples will span these two worlds to some extent. It is not easy to develop such policies. If we are talking about pregnant women and substance use in a traditional context, the traditional policies will shape the response differently than if we are talking about pregnant women and substance use in the mainstream context. For instance, consider the meaning of a word such as "pregnant" in its cultural context. The Gitxsan word for pregnancy is "ubin." The spelling may be wrong but the connotations that go with the word and concept are broad. The concept includes reincarnation of ancestors and going forward to the next generation. The mother has an important role to play in securing a place of belonging for the child. She is a party to all that occurs with the pregnancy. There is no dichotomy between her and her child. But she isn't solely responsible for the child either. She and the child are intricately linked to their extended family and to their Clan House. The concept includes a kind of anticipation and planning, and a sense of responsibility that is not captured by the word "pregnant" in the mainstream cultural context.

Finally, we considered the framework developed by Dr. Christine Locke (1998) and many other committed individuals who work with pregnant women who use substances. Factors making up this framework include respect, hope, understanding and compassion. Each of these frameworks informed our thinking about the data, the organization of the case study and the final recommendations.

The Participants

The participants of the case study were predominantly front-line workers and grass-roots Gitxsan women ranging in age from youth to elder. Some of the front-line participants interviewed were also leaders in the Band governance structure and in the traditional governance structure or both. Their perspective as leaders, although not the focus of the interview, added an insight into the dynamics of leadership in the community.

The grass-roots participants were diverse in age and interests. All were touched in one way or another by substance use and addiction. The grass-roots participants know better than anyone else what they and their families need. They are the potential consumers of government programs and services, and as such know whether or not these programs and services meet their needs. They know who they can trust and who is motivated by self-interest. They also provided perspectives on traditional governance structures and practices that were invaluable.

The front-line workers are responsible for implementing existing policy and programs to deal with the social and health issues in the community. They know their clients and their community, and they know whether or not policies and programs are effective. They know the barriers. They are the link to management, leadership and to the people. They have many roles in this capacity: advocate, referral agent, caring human being, leader and others. They go above and beyond the call of duty on many occasions. One worker told us about providing personal resources to help a woman return home from a treatment facility because policies prevented her from accessing travel money.

All of the participants offered a wealth of information and insight. For that, we thank them deeply.

The Broad Government Policy Context

The Gitxsan and the Wet'suwet'en people gained national recognition through the historic Delgamuukw v. British Columbia decision made by the Supreme Court of Canada (SCC 1997 Vol. 3). The Gitxsan and Wet'suwet'en hereditary Chiefs on behalf of their people decided to take their claim to court because their treaty negotiation process with Canada and British Columbia came to an impasse. At the trial level, the Gitxsan people presented evidence of their rich culture, their system of traditional governance and laws. Although they lost at that level, that decision was overturned by the British Columbia Court of Appeal and affirmed by the Supreme Court decision. The decision recognizes that First Nations' claims to the land have never been extinguished and sets the legal foundation for land claims in British Columbia. It also recognizes Aboriginal title and the collective nature of that title. Recently, the Gitxsan Hereditary Chiefs and the province of British Columbia signed a Reconciliation Agreement, allowing for bilateral negotiations to continue on certain issues. These negotiations include support for cultural approaches to improve the quality of Gitxsan life.

The Gitxsan people are currently governed largely under the authority of the federal *Indian Act* and policy. Administrative authority is devolved from the Department of Indian and Northern Development to the local Band Councils. There are 197 First Nations Bands in British Columbia, approximately 33 percent of Canada's 609 Bands. The Gitxsan people who live on-reserve reside in six communities governed by Band Councils: Gitanmaax, Gitsegukla, Kispiox, Glen Vowell, Gitwangak and Gitanyow. Five of these Councils are members of a larger structure called the Gitxsan Government Commission, which is mandated to address the issues of the Bands as a collective body. One Band has remained independent from this governing body. The *Indian Act* also determines who is a status Indian and thus a member of these Bands. Band members are entitled to federal programs and services administered by Councils. Not all Gitxsan people are Band members.

It is difficult to determine how many Gitxsan citizens there are at this point. Although there are about 2,000 Gitxsan people living in the six communities, most live away from their traditional lands. Some are legally defined as status Indians pursuant to the *Indian Act* and as such are entitled to Band membership and to live on a reserve. Status Indians who do not live on-reserves have limited access to First Nations specific programs and services. Aboriginal people are entitled to provincial programs and services but are often denied access to these because of misunderstanding among providers about which government is responsible.

Although the Department of Indian Affairs and Northern Development has major responsibility for policy that affects First Nations people, other federal departments also have responsibility for programs and services. For example, Health Canada Medical Services Branch is responsible for Indian health programs and the Department of Justice is responsible for the justice system on-reserves. The provincial Ministry of Aboriginal Affairs has the main responsibility for participating with the federal government and First Nations Bands, Tribal Councils and Hereditary Systems to negotiate land treaties. The provincial government also provides services to First Nations people living off-reserve. The provincial government is also in charge of the *Societies Act*, which the federal government oversees through income tax legislation. Aboriginal people pay for these programs and services through personal income tax, organizational taxes or through human suffering.

First Nations people on-reserve deal with many levels of governance. Federal and provincial governments play a large role. Often, First Nations people are required to set up societies if they are to receive public funding, thus creating several other governing bodies in the community. At the same time there is the Band structure, created by the federal government. All of these systems are present, even in the smallest Bands with a few hundred people. These complex governing structures and processes are difficult to negotiate and costly to administer. Many resources are spent on far away government bureaucracies and do not benefit the local First Nations communities or Aboriginal people. Yet funds are rarely set aside to support traditional systems of governance and help them rejuvenate.

The historical events and governing structures noted above set a legal and political framework within which Gitxsan nation building can occur. Healing from historic trauma, empowerment, and capacity building of the Gitxsan people can become a reality for all Gitxsan people, regardless of where they live. Repatriation of Gitxsan citizens who are disconnected from the culture and the Nation can become a priority. Each one has a birthright to claim and should be welcomed home. They belong to the Gitxsan Nation and as such have citizenship rights. They have a place in the social structure of the Gitxsan, and have a responsibility to help reconstruct and re-invigorate the culture, its institutions and systems of governance. At the territorial level, the Gitxsan are in a process of rebuilding the social cohesion of Gitxsan society using governance tools available in mainstream institutions and those that exist in their traditional system of governance. These traditional tools of governance are based on Gitxsan values, beliefs, attitudes and assumptions. This process of rebuilding social cohesion is very slow and costly, but will build the foundation for the years of political, legal and social development that lies ahead.

A Community in Transition

All of the above suggests that the Gitxsan nation is undergoing a transition from the federal *Indian Act*/Band Council model of local governance to the Gitxsan hereditary model of governance. At present, both models exist side by side. Although the hereditary system of governance is politically recognized and utilized, it does not have the same resources to draw upon as are available to the Band Councils. Ultimately, the resources needed to do the work will come from the traditional territory of the Gitxsan.

The transition process is made more difficult because the Band Council system and the traditional system often do not support but conflict with each other. When the Gitxsan people were relegated to reservations, their ancestral lands was taken as Crown land and people who lived on these lands were displaced. They were sorted into particular Bands and often, families and their Houses, the traditional governing bodies, were broken up in this process. Six reserve communities were created, governed by Band Councils. This conflicted with the traditional Gitxsan governance structures, where there are four clans and several clan Houses, governed by Hereditary Chiefs. These Hereditary Chiefs were and still are responsible for and accountable to House members and responsible for holding traditional territory. Resources harvested from the territory are to be used for the benefit of the House members. House members provide support and connection to each other and work cooperatively with those in other Houses. This support is most evident today in the traditional practice of death feasts.

The operation of Band Councils was modeled on European notions of governance – also at odds with the First Nations system. The *Indian Act* determined who could be considered a status Indian and thus the notion of status and non-status confuses who can participate fully in the governance of the Bands. Band membership is determined patrilineally. This method of determining membership has had the effect of undermining the traditional matrilineal system of clan and House membership. Until about 30 years ago, First Nations women were excluded from Band governance, whereas in the Gitxsan traditions they played a strong role in the governance of the nation. Moreover, until recently, First Nations people were legally denied the right to live in the context of their culture, and their children were taken from them and placed in residential schools. These actions were part of the government-sanctioned policy of assimilation. The children were later placed in foster homes and many ended up in the criminal justice system. Returning to traditional systems of governance given this history is very difficult. The transition process may create internal conflicts but many of these conflicts are a result of this history.

It is not the intent of this report to provide a detailed analysis of federal and provincial policies and services to First Nations people, but to highlight how the laws, policies and services of each level of government affect how First Nations people can deal with their struggles at the community level. Not only are there many different levels, policies and people to learn about – many that are changing all the time – these often conflict with one another and with traditional ways of governing.

In addition to its transition of governing structures, the community is undergoing a transition in the way it deals with individual and community issues. For many years, health and social services offered by governments to Band members were based on European ways of viewing social problems – as individual problems to be dealt with case by case. This approach has been criticized by European authors for the damage it has done to community life and to a sense of social responsibility in the general population, and its effects were devastating on First Nations' communities.

When people were taken away from their land and placed in groups that did not represent their traditional families and Clans, there was a deep sense of dislocation experienced by First Nations people. Their natural order had been removed and, in its place, was a system that contradicted traditions. The sense of who you were, where you belonged and why you were important was taken away from the community as a whole and from individual members. Belonging and value are absolutely crucial to the development of healthy individuals and communities and these are precisely what were lost. When Aboriginal people reacted to this deep sense of loss by withdrawing from participation in Canadian political, social and helping systems, they were seen as uncooperative and apathetic. Instead, they could have been seen as resisters, determined not to collaborate with those who had taken away so much. When whole communities reacted to the sadness and loss, a community way of life that involved apathy and despair took hold. Children were removed and more despair resulted. The task for First Nations' communities now is to regain a sense of belonging to the earth and to the community, to connect with the rich history of traditions, and to value these again. It is important to value those who went before and to see their despair as acts of resistance and courage.

It is also important to understand that individual behaviours are a reaction to a history of colonization; at the same time, individuals have the power and capacity to take actions to change their behaviour, with support. Sometimes even one person offering help, words of comfort and compassion can make the difference. Many people are survivors. They have demonstrated resilience, the capacity to survive in the face of overwhelming odds against them. This resilience is important to celebrate and to understand.

The aim of health and social services is to help people know who they are, value themselves and their community, and find their place – to be connected again. Such services help celebrate resistance, survival and resilience. This is the journey of healing, and the focus of the health and social service efforts of the Gitxsan people.

This journey requires a total re-thinking about what health and social services are. How could they be constructed and delivered in traditional ways while at the same time incorporating what is useful from Western knowledge? How can they become the Gitxsan's system for the next century? It is important not to allow fear or foreign systems and attitudes to drive community efforts.

At the same time, there are pressing problems that affect all community members. As Gitxsan women, we have concerns about the impact of substance use and addiction on family members, their communities, their culture, and on the very important work the Gitxsan people are engaged in at this point in their history. There have been formal health and social service needs assessments in preparation for the delegation of health and social services from the federal government to the Gitxsan people, and for the delegation of child welfare services from the province to the Gitxsan. Although we do not have the results of these formal assessments, we know that the issue of addictions and pregnancy is an important health and social concern in the community. The following describes the work now under way that has an impact on this issue.

Self-Government

As mentioned above, the Gitxsan people are currently dealing with the consequences of the Delgamuuk case. The self-government initiative is led by the Office of the Hereditary Chiefs. This includes treaty negotiations, bilateral agreements and the like. This initiative is legal and political in nature and broad in scope.

The Hereditary Chiefs recently signed a Reconciliation Agreement with British Columbia to negotiate a bilateral agreement on a variety of issues, including health and social services. It is hoped that the bilateral agreement will provide the authority and resources so that the Gitxsans can develop their own flexible and autonomous decision-making processes to deal with health and social services. This is a crucial step as it could provide the resources and the decision-making power for the community.

A Community Healing Centre

Wilp si'satxw is located on Gitxsan territory, serving the First Nations communities in the north. This healing centre focuses on alcohol and drug addictions using methods that harmonize with traditional approaches. Central to their work is helping clients get in touch with their spirit and come to have faith in themselves. They learn to pray and to hope, to heal their spirits that are wounded and hurt, through sweat lodge ceremonies and the medicine wheel. Gali Skalun, writing in the Wilp newsletter *Four Directions*, describes the need for spiritual renewal in these terms:

> First Nations spirituality is the establishment and maintenance of a very sacred relationship between the pledger and the Creator.... In his book Mailis, the author, asks of his informant, Fools Crow, the old Lakota Holy Man "...what did Wakean Tanka give him that made his power so effective and had brought such remarkable serenity and endurance to his life." Without hesitation he answered, "Inner peace."

Pledgers come from all over the province and from other provinces, many with a variety of addictions and cross-addictions in addition to alcohol use. They enter on a voluntary basis and participate in a six-week co-educational program that accommodates 18 at a time. The board of directors represents many different communities and groups in the Northwest of British Columbia. The notion of community healing also pervades the philosophy and programs of Wilp. For instance, a summer youth camp, outreach programs to young people, and social activities that emphasize family involvement and follow-up are a crucial part of the programming. Given limited resources and the need for direct programs for those suffering from addictions, there is the expected tension between treatment of individuals and broader activities to prevent addictions and sustain sobriety. The centre has existed for 10 years and is currently undergoing an evaluation of its programs.

Wilp does not see many pregnant women in its program nor does it have special programs for such women. Wilp staff ensure that pre-natal care is available and that clients are provided with information about Fetal Alcohol Syndrome (FAS) and Fetal Alcohol Effect (FAE).

> A lot of spirits are wounded and hurt, they come to have faith in themselves, they learn to pray and have hope. There are sweats lodge ceremonies here. Quite often pregnant women will go in provided it's okay with their doctor. They get in touch with themselves.

The Centre is currently examining where it will go in the next decade. Special outreach to pregnant women was identified as one possibility.

There is also concern about the fact that younger and younger children are using drugs and alcohol and that the choice of drug is changing from alcohol to cocaine. There is a lot of concern about FAS and FAE. The participants expressed concern about the primary and secondary effects of FAS and FAE on children and adults who are coming through the drug and alcohol counseling and treatment centre programs. There was recognition that those who have been affected by FAS and FAE require different kinds of approaches from staff and others to tackle their addictions.

Health Systems

Although negotiations are under way for more control of health and social services, the present health system is a result of a health transfer agreement between Health Canada and the Office of Hereditary Chiefs (OHC) that created a legal entity to administer the Gitxsan Health Authority (GHA), now in the fourth year of a five-year project. In the first years, the GHA went through growing pains as it tried to find a structure that would meet the needs of all of the Bands, support traditional structures and beliefs, and serve the whole community, regardless of Band divisions. The intent of the GHA is to provide health planning and services to all of the Bands rather than each operating on its own. The programs emphasize prevention, culturally relevant and appropriate approaches, and flexibility to meet community needs. The GHA is committed to professional development of staff and using those in the community as staff members. Since the project began, one Band has opted out of this initiative. It is negotiating a separate agreement with Health Canada.

Before the creation of the GHA, the health staff were accountable to the sponsoring Band and were responsible for delivering these programs to Band members on a one-to-one basis, and to act as a referral agent and a liaison to the medical community. Their role in the larger scheme of things was relatively limited and isolated from their peers in other communities. After the creation of the GHA, the Community Health Representatives program and the National Native Alcohol and Drug Program Addictions Counselor program were transferred from Band administration to the GHA administration. They are all involved in planning for the GHA. The communities will be involved in community forums and will be supported as individuals open up to deal with historic wounds.

Child Welfare

Many responses to women with addiction problems during pregnancy and afterward result in action by child welfare officials. This system is also undergoing change. The Gitxsan Child and Family Services (GCFS) project is an initiative led by the Gitxsan Government Commission and is funded by the Department of Indian and Northern Affairs under the First Nations Child and Family Service program directive 20.1. The project is in the second phase – the planning phase – of a three-phase project. The plan is to create an agency that will deliver child and family services to Gitxsan communities. Authority for that agency will be delegated through a Delegation Enabling Agreement from the provincial *Child, Family and Community Service Act*, giving Gitxsan social workers full authority to act as child protection and resource workers. The same independent Band has opted out of this initiative as well. In practice, however, its community members will be served by the agency because the approach to child and family services will be culturally based and transcend artificial barriers such as independent Band status. However, the fact that one of the six Bands has opted out of these two initiatives will have financial implications.

The GCFS intends to utilize and build upon traditional systems such as the extended family system, the clan and House system. These systems are based on different philosophical views of the world, and reflect the different values and beliefs that inform them. The Gitxsan world view is not bound or restricted by the federal Band systems of governance nor the nuclear family ideology.

Although it will be possible to initiate traditional responses to child welfare under the new system, it is important to note that government legislation and policy will still have a large impact on what

Gitxsan people can do. The new agency will be delegated to implement the *Child, Family and Community Service Act*, the legislation governing all child welfare in British Columbia. This act places more emphasis on child protection, and less on prevention and community involvement. Gitxsan people will be challenged to meet the requirements of the act and policy, yet adapt it to their own world views. For instance, much of the funding for child welfare is based upon the numbers of children in the jurisdiction and the numbers of children in care. Funding for those not in care, as government defines it, is variable. Without changes to these funding formulas, it will be difficult to mount traditional approaches. Another society will be set up to administer child welfare, again potentially isolating it from other services and from community members. Already the GHA is suggesting that staff from both societies should share staff development opportunities and work closely together on community issues. A respondent from the Community Healing Centre suggested pooling funding for AIDS and developing a coordinated response. Flexibility of funding criteria will determine the possibility of a united approach.

At present, child welfare services operate somewhat differently in different Bands. All use their social development staff to provide income and family support services. Sometimes, if children are at risk, they can be placed in the home of a relative and the family is provided financial support through the income support program, without involving provincial child welfare authorities. If this is not possible, however, provincial child welfare workers are responsible for investigating and making plans for children. One Band has developed a child welfare committee that has assumed much of the control of government child protection workers. If concerns are expressed about children, the committee, including the government child protection worker, will notify the hereditary chief of the children's House and plans will be made among the House members to care for the children. This process is enabled through a protocol agreement. However, if these members are not also Band members, they cannot receive financial support as these are distributed through the Band system and family members are subjected to eligibility criteria.

Cultural Approaches to Community Issues

This time of transition is also focused on strengthening cultural responses to a broad range of community issues. Gitxsan culture has always been a source of strength in the community. However, it is undeniable that it has suffered some damage as a result of historic abuses and is in need of repair and renewal. In our interviews and group sessions, there seemed to be a strong feeling of self-determination, of healing of families and cultural renewal. In many cases it was not what was said but how something was said that created this feeling. There also seemed to be a sense of urgency to do what was necessary to fulfil their aspirations for their people. There was a sense of recognition that they were standing on the shoulders of giants; i.e., the feeling that "our ancestors got us this far – we can do the same for future generations." However, cultural knowledge needs to be preserved and shared with the community members. Not everyone in the community knows who they are and where they belong, and what their roles and responsibilities are as a Gitxsan person. Cultural systems and institutions need repair and renewal. There needs to be a credible and trusted alternative. Resources from the territory need to be harvested, and the wealth redistributed according to traditional values and beliefs.

There are cultural initiatives in the community. Gitxsan language is being taught in the elementary schools. Culture camps are teaching the children about culture and traditions. These camps cost money and poor families may be unable to afford them. One participant told of the concern that was raised with a family about young boys and their use of alcohol and marijuana, and how it was dealt with culturally:

> And so what they did is they requested the two other families here in our arena have a cleansing ceremony, which we did. And the young men sat, and the parents and the uncles spoke on how they felt about what was happening with their son drinking alcohol and smoking pot. And we wrapped it up with a closing and a snack.

This traditional practice brings everyone together, and shares the concern and the responsibility for the wellness of the young boys. Uncles are a very important part of Gitxsan culture. They have primary responsibility for teaching their sisters' children right from wrong. It is very important that uncles be good role models. This experience sends the message to the youth that they are loved and supported. It gives them a sense of value and sets a standard of intolerance for alcohol and drug use. It also lets the youth know their behaviour affects a lot of people they love.

Others noted the use of traditional talking circles as an additional example of cultural approaches that were being initiated informally into the community:

> I think realistically what people are doing more is the talking circle. In that environment people are opening up to issues that are barriers to them to be healthy and whole. I think that avenue should be explored. A talking circle is a good place to bring things out. And then, the ideal would be that professionally trained people, because when you're trained you get the broad picture, could help.

> So in the community of Gitanyow they have an emergency response team, they've got talking circles going so they are actually doing the work.... I told her I would like to start participating and feel and experience that they are doing. Maybe they will have a ripple effect where it will start happening in all the communities.

> We were invited to a potlatch supper where the baby was born premature and spent two or three months in the hospital in Vancouver. The grandparents held a potlatch supper and invited people to welcome this baby home and show the parents that there was family and friends there to support them. And my husband said, "We'll go because this is part of building the family structure by showing the grandparents and parents that they are part of a community and a family and they have an important place within that structure." We went and they welcomed the baby and smudged the family down and then they did sort of a mini-feast. They gave us fish that they had dried that summer. So when we went home it was good to see the community rally around this family.

There is a community challenge during this transition period as many of the staff in programs were trained by governments to work in a particular fashion and now must take on new approaches and methods. Two comments outline the challenge:

> We set up mediation training with the Justice Institute in June. And again all the front-line workers were invited but not all showed up again. It seems like it's the same few that don't participate. We have a number of workers who are in positions to be trained to be more effective in their respective positions but they are comfortable where they are at, that they don't see that they can do more for other members.
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> The work that we wanted to do was bring in traditional healers or spiritual people. There is one lady that we did a retreat with at Wilp and at the end of the week we had a sweat. It was open to GHA staff and the three boards. Nobody wanted to participate other than the Western staff and board and it was really worthwhile. It is this type of work that we need to do with our people and start talking about healing our Nations. That would be the place to start.

Women in the Community Respond to Substance Use During Pregnancy

Many people we interviewed individually and in focus groups had a great deal of knowledge of and concern about women and substance use during pregnancy. This in itself is a major community strength. Generally speaking, it is largely the women in the Gitxsan community who take a leadership role in social development. They promote social cohesion and a sense of well-being in the community. They are at the front lines to raise and take on the hard social issues in the community. They are the voice of conscience for the people. Often they do not have the decision-making power or access to resources to create the change that is needed. Thus they take issues on as their personal contribution to their people. Women talked about the need to re-establish their place in the community as a crucial step in dealing with these issues:

> I know that we're working towards acknowledging the hurt from residential schools. I know that it would be good to go back to our traditions, like we used to have ceremonies and rituals that we go through when they become a woman for the first time. We're trying to bring that back. Get in touch with the House members and have them use their authority over their people. Right now it's the government way where they don't recognize us as Gitxsan women – we're just put under the same umbrella. There's no sense of identity there.

Women in the community address substance use during pregnancy in many different ways. Some women hold both traditional and Band council power, and work within various health and social services. One woman, a Hereditary Chief, commands respect by her very presence. She has proven her commitment to her community in a variety of ways and the people know they can trust her. She acts in the interests of her people, whether for her reserve community or for her House members. She is a great role model and symbolizes resiliency. She gives hope. She speaks to young women, women who are pregnant, and her words can be heard.

Those women who do not have this recognized political power nonetheless use their personal informal power at the grass-roots level. One participant told of her concern about FAS. She educated herself so that she could do something about her concerns. Instead, she became frustrated by the fact that she sees the problem in its many dimensions yet still cannot do much. Lack of resources was a primary problem. She also felt that the issue had been side-stepped:

> I think we have to have the issue on the table and people talking about it directly because that's not what's happening now. People who work with affected children talk about the issue, but not the family. I haven't heard people who have affected children talk about the issue and why is it? I think there's still a lot of guilt there.... I think workshops are useful but I think what we need are supports for parents so they can actually start talking about how we can work with what is present. When we do workshops we always talk about the issue and raise concerns, but the follow-up is difficult to carry through unless you're in a program where you can get funding.

Although she worried about the lack of understanding in the community, even among the leadership, about the impact of substance use during pregnancy, she hoped that education would be useful in broadening understanding and helping staff offer appropriate responses. Most of the participants were very aware of the importance of being a good role model for younger women and making sure that they could see how to live without substances.

Many of the respondents act as informal change agents throughout the community with little or no financial resources. They talked about a personal commitment to facilitate positive change with their family, youth and their community, despite lack of resources and support from community leadership. As one participant said:

> I've been working with young moms around here for about five years, we have a group that meets every Monday and we bonded and I know that there's trust there.

This attitude of personal commitment to the "cause" in any capacity is often the norm among First Nations people. Years ago, the unifying "cause" was resistance. The Royal Commission on Aboriginal Peoples says the cause today is "renewal." There are many branches of renewal today: healing, cultural, political, territorial and much more. This attitude of deep personal commitment may be attributed to a growing sense of political development and cultural renewal among the Gitxsan people as a result of the years of work put into the Delgamuuk case and it could be also attributed to the symbolic power of the First Nations healing movement.

Women spoke of the necessity of healing and their role in encouraging healing processes. One participant told of her experience in a First Nations addictions treatment centre. She learned about the generational impact of the residential school experience. When she came home she had a better understanding of the dynamics in her family. She brought this understanding to her family dynamics and to her work in the community. She feels that this understanding promotes compassion. Many women talked about the first step in healing and building trust among community members:

> That's the big area that needs to be worked on – trust. I'm not sure how to go beyond that except to work with families and hopefully with talking circles. I think that needs to start within all the communities. Start with the healing of mothers you know because they are the backbone of the Gitxsan society. They're the ones that do all the material work with the food and money in the feast hall.... The Gitxsan women have to rise and just say enough is enough. And now let's start doing something. Let's start helping our people.

Community Messages About Women and Substance Use During Pregnancy

Two strong messages came from our respondents. The first dealt with the importance of prevention and using every means possible to help young people understand the impact of alcohol and drug use on the developing fetus. Many creative initiatives had been taken.

One of the important comments made by staff at the Wilp Centre was the changing nature of their clients, perhaps reflecting the changing demographics of the First Nations population overall. Over the last couple of years, the Centre is attracting younger clients – 18 to 23 years of age – and also getting calls from people who are workers with younger youth and seeking programs for them. In one way, the program has great potential to prevent alcohol and drug use during pregnancy, although it is stretched to provide adequate programs for youth and is challenged to know how to do this well. As one respondent said:

> One of the initiatives that community health nurses have tried is providing education workshops on the effects of alcohol and drugs. I feel a lot of work needs to be done in educating about this, especially young women. In the Hazelton High School there were 18 teen pregnancies last year – that's pretty high. I believe at least nine were abusing alcohol.

Other comments about prevention include:

> I think that we can no longer just talk about it but we need to start doing work in the communities by providing more programs in the area of prevention.
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> We have activities in the communities to promote awareness about drugs and alcohol. For example, during National Addictions week in November, front-line workers go into schools and talk about A&D. Each community takes part in doing something in their community. Everyone is invited. As well, the Northwest Band Social Workers Association is promoting awareness among resource workers about FAS.
>
> Policy in regards to GHA has taken a good turn in the last six months. We are really focusing on educating before, instead of being a drug and alcohol counsellor after. [We're] not being reactive anymore, but promoting education, helping not just in the schools but with the Wilps and its members.

> We've also done the First Nations shield workshop and it has helped the RCMP in Hazelton…in dealing with substance abuse. It was training people how to educate others about substance abuse and actually going into schools and educating young children. Children are shown all the different types of alcohol and narcotics.

The second message reflected the real challenges facing those involved in intervention and treatment of substance use in First Nations communities. The perspective of wholistic healing has tremendous meaning yet is a substantial challenge. The issue of residential schools and their impact on substance use provides one illustration:

> I went to residential school. I believe that people who didn't go to residential school are more open. At the residential school, they did our thinking for us. They took away our culture, our language, our parents, our guidance. My mom didn't teach me. When I grew up, I followed my mom. I couldn't teach my children. All I could give was my love. That hurt so much…that I lost all that through the silly residential school. When I left the residential school, I thought I was so smart. Yet at 18 I didn't even know I could get pregnant, or that I was pregnant…. We didn't have anyone to teach us. Through residential school, we had no guidance of any kind. So, many of our people thought that alcohol was how to get to know people. That's what I got into. I drank for all of my life except when I was in jail. Alcohol got me into jail – doing stealing, murder, whatever…. The people who are in jail are mostly from residential school.
>
> So once I started seeking counselling I got into a three-month program on life skills and from there my counsellor set me up to go to a program in Round Lake called Survivors of Trauma. And I took that for six weeks and it was an eye-opener for me to see that the majority of my family are from residential schools where all the abuse happened. That's the reason a lot of my family abuse alcohol, because of the pain there, from the denial that has affected their lives. A lot of them say that they were never sexually abused, that's a biggie. But I don't think it's that that has really affected our family. Its just the bond of all of them being taken away and not being able to treat brothers and sisters like brothers and sister. Now that they're grown, how do you expect them to know how, then they lost it a long time ago.

Respondents commented on the number of people who had been through residential school and others who had experienced a myriad of issues that directly relate to their substance use:

> We did seven days of workshops and two performances in two communities called "reclaiming our spirits" with David Diamond. Actually it was doing skits about being sexually abused and the different sounds of clicking. We did a lot of work with ourselves with dealing with trust issues. A lot of people dropped out in the first two days when they realized it was dealing with sex abuse…. I found it amazing for our workers to have really huge trust issues. We have to deal with our own stuff before we can become helpers, but a lot of that work hasn't been done yet either.

> The women that are pregnant – they deal with a lot of personal issues as well as addictions, childhood issues, sexual abuse, family violence. They get to share a lot of their personal pain here as well as take a look at themselves so they can be a better parent for the child they are carrying.

Some respondents are also challenged to serve clients with FAS or FAE themselves and to design programs that respond to their learning styles:

> I'm seeing a lot of people coming here that are affected by FAS. They need special programs; we help them as much as we can.
>
> You have to get it across in a short span of time where you don't lose their interest. And you make it fun. So you have to be creative on getting it across. You have to find ways of getting them to give you answers. You make it fun. I've never been real keen on rewarding. Just the reward of letting them know they are special, that they are loved, that they have good answers makes them feel better. It's not something that some of them are used to hearing. That's what hurts me the most.

Issues of Concern

All of the above-mentioned initiatives are contributing to the transition from government control to self-government, and to tackling the issues of women and substance use during pregnancy. It is too soon to evaluate their effectiveness in moving both those processes along. Although we are a part of the community, we do not live there. Our assessment is not as rich and deep as those who are residents of Gitxsan communities. However, as we interviewed residents of the community, we heard their comments on particular issues that need attention. We also had questions ourselves. Although these comments and questions may reflect our lack of knowledge, they may also prompt those living in the community to take new actions.

Input from Women and Youth into Overall Policy and Decisions Affecting Their Daily Lives

Women have a powerful and honoured place in the Gitxsan culture. Given that all of the above-mentioned initiatives deal with the issue of pregnant women and substance use, either directly or indirectly, and all of the initiatives necessarily involve policy development processes at the local level, a larger question is: How are pregnant women who are addicted involved in these policy development processes? How are front-line workers, most of whom are women, and grass-roots individuals involved in these policy development processes that will shape their lives?

We must keep in mind that we have a young population. They need the help of adults to get ready to assume the role they will take as leaders in the community. The traditional ways of transmitting the culture is eroded and needs rebuilding. For example, young men have no problem walking away from responsibility for a child born outside of marriage. This behaviour flies in the face of the tradition called *wil ksa lex*. There are youth workers and youth groups in community that trying to meet the needs of youth. Is their work ad hoc or is it part of a community strategy? Does the Gitxsan

Nation have a youth empowerment strategy? We need to research why children are turning to substance use. One possible reason is there is that nothing in the community for children to do. Families live in poverty or have very limited resources. It costs money to be part of healthy activities for children and pre-teens. Transportation issues are a problem. The communities are spread out. There are a number of single parent families. How involved are the youth in the decisions that affect them? Do they influence planning, policy development, and the kinds of resources and programs made available to them?

Rejuvenating Culture and Reforming Structures

We were unable to discern whether there was a connection between the Band Council system and the Hereditary system. It was generally felt that there was no formal interface between these two governing systems.

Right now, structures of traditional governance intertwine and are enmeshed with structures created by the federal and provincial government. Frequently, the Gitxsan community tries to use these models of governance to implement their many aspirations in the context of Gitxsan culture, institutions, beliefs and values – but it cannot be done. The philosophical underpinnings of Gitxsan cultural systems, practices and laws cannot be squeezed into these structures and be expressed in their full vigor. For example, the Unlocking First Nations Justice initiative has been created under the Attorney General's diversion policy. The initiative attempts to use traditional systems to restore balance and harmony between victim and offender, but there is more to this process in the Gitxsan world view than what is recognized under this diversion policy.

Resources are often needed for these approaches to be effective but they are not available. Furthermore, not all Gitxsan victims support this traditional approach. They feel further victimized by the process. Similarly, the same problems arise in the context of child welfare initiatives, where there is recognition of the extended family system and a role for traditional leadership. And in the context of health, the same problem arises in health transfer initiatives. The initiatives act as a link to traditional systems but, without models of governance that are inclusive and adequately resourced, the structures created to do many important jobs will not be as effective as they could be otherwise. This issue is beyond the scope of this study, but is an important one, given the opinion of participants that the culture and the beliefs and values that underlie the traditional laws and institutions can be an alternative approach to dealing with the many social ills in the community, including substance use during pregnancy.

The notion of two world views conjures up the image of a parallel community co-existing and two separate world views. At this point in Canadian and First Nations history, there are no new structures designed to do the job of bringing these two separate world views together in a legal relationship that recognizes different structures. Even the Nisga'a treaty is being characterized as a municipal model of governance. Creative legal minds need to be drawn upon to come up with something different.

Participants felt that there were so many strings attached to any program activity; i.e., that staff were constrained in what they could do with many of the programs. Narrow criteria create barriers to resolving problems in a cultural context. The participants expressed a lot of frustration and feelings of helplessness given the scope of the work that needs to be done just to stabilize a community and protect the children. In the Gitxsan culture, accountability is to the family and the House. Front-line workers try to honour this in the context of their programs. Yet they are accountable to their employer and to the government because the funds are public funds. There is a definite need to access the resources for the work to be done from the wealth of their own territory. This wealth needs to be shared with their citizenry living in urban centres. Citizenship rights go with the individual; they are not based on residency.

Government needs to create programs and policies that are flexible enough to accommodate community visions and approaches without compromising the integrity of the community. Are there mechanisms in place to ensure these federal and provincial policies don't also drive the vision and work of the Gitxsan people?

Putting the Issues on the Table and Managing Conflict

We heard how difficult it is to discuss many of the problems facing the community, even though everyone knew about their existence and many were worried about their impact. The easy access to cocaine and its effects, wife assault during pregnancy, poor nutrition, and child abuse and neglect are issues of concern but are not openly discussed. The issue of substance use during pregnancy was not openly talked about either. When it is discussed, it is in the context of the damage to the child and its future. By focusing only on the child and not also on the woman, her issues are not resolved and she will continue to have babies while continuing to use substances.

There are many reasons why it is difficult to talk about these issues. People have stereotypical views of First Nations communities, and voicing opinions could support the stereotypes and make progress even more difficult. Many times, the experiences have left a deep mark on the self-esteem of people so that it is hard for them to talk and involve others in talking. As one worker said about working multiculturally:

> We do have involvement from all of those areas but the hard part is getting the local people to band together and to start doing the talking. But to involve the rest, because the trust issue is a big issue when you're working with non-native people together. People don't feel good about themselves and where they're at, so they don't want to be involved in working with the Ministry because they don't feel worthy.

Many of these issues are very close to home, even for leaders in the community. To acknowledge them can jeopardize their own position in the community and their own power. The importance of land claims and self-government, fundamental to many reforms, are such that sometimes leaders think that the other issues can wait until these ones are settled.

One way that some of these issues can be talked about is in relation to residential schools and child apprehension policies. It is now known that historic institutional childhood sexual abuse at residential schools, in foster and adoptive homes, and families and communities cause trauma to the child and is one of the underlying causes of low self-esteem and substance use as one reaches youth and adulthood. In many cases, these abuses are the defining event for these people. A lot of work is being done to try to address the healing of victims of residential schools. We need to spend as much effort at the community level to deal with the impacts of abuse in people's daily lives. Workshops are brought to the community but many people will not attend for a variety of reasons that only they know about. Other approaches need to be explored.

Another way to begin to talk about these issues is to look outside the community and our own history to how others are dealing with colonialism. It might be useful to engage in international research. African government officials are looking to First Nations healing concepts to help them with their work. We as survivors of colonialism can also look to them for an exchange of ideas. Perhaps United Nations working groups are doing some work that could be helpful.

Although conflict is a necessary and expected part of community living, the present circumstances create the potential for a great deal of conflict in First Nations communities. Governments inevitably try to drive the agenda, and community members must resist and yet accommodate this in some ways. Some will feel the leadership is too lax with government, others too harsh. What are ways in which some conflict can be analysed and understood as the natural result of the conflicting forces outside the community that is expressed within the community?

The colonizing process took away many traditions, including those that dealt with conflicts and potential conflicts. One such tradition was "am ni goo wat koo" (the spelling is uncertain). This tradition provided for peaceful links between neighbouring communities. If a woman married a man from another community, he was entitled to fishing and hunting rights on her lands for the length of his lifetime, after which the rights were extinguished. There were also traditions dealing with the land between neighbouring communities to avoid conflicts. These laws and traditions were lost with the loss of the Potlatch and must be recovered in the emerging traditional structures.

Participants expressed a sense of frustration with a host of things but particularly over the fact that the community didn't seem ready for the responsibilities it needed to undertake. The other side was also expressed: that if you don't start, you will never learn. There needs to be some tolerance for growing pains.

Leadership During a Time of Change

Given the many issues confronting the Gitxsan people as they try to move to more traditional ways of living and working, the role of Hereditary Chiefs needs to be re-established and redefined. House members are scattered and many Gitxsan people don't know where they belong. Many have been disconnected from their cultural ties for so long that they don't recognize the legitimacy of the traditional system. They believe that the traditional ways are gone. But this is not so. There is a lot of effort to redefine who the Gitxsan are in the context of the 1990s.

One way that all leaders can unite is in the context of community tolerance of substance use. If pregnant Gitxsan women are using substances, the traditional leaders, including Hereditary Chiefs and elders, could take the initiative to do something for their community's women who may be unaware of the consequences of their behaviour or who may not be able to access support. People see pregnant women drinking and using drugs but tend not to say anything. Traditional leaders can take on the role of teachers and advocates. All leaders need to challenge the high level of tolerance for substance use in the community. Excessive use of alcohol and substances is accepted as a social norm at social and sporting events. In this context, the community does not lend itself to relapse prevention. Residents go away to treatment only to come back to the same social environment.

If culture is to provide an alternative approach, the traditional leadership needs to be knowledgeable about the issues that arise in this context of substance use and addiction. At this point, they are unable to marshal the resources needed to meet the needs of their House members. Under the emerging bilateral agreements with British Columbia, there is potential to remedy this problem and to negotiate a comprehensive approach to some of the issues that plague the community. Gitxsan participants had a lot of good ideas on how to help the women. What is needed is for leadership to talk about these ideas and develop a strategic plan.

Participants expressed concern that there is so much focus on the big picture (negotiating with provincial and federal governments) and that, in the process, the leadership is losing touch with the people. Women are taking leadership roles in social issues but they are not well represented in the negotiations with provincial and federal governments, and there is a separation between overall planning and social planning.

Leadership in the context of Band Councils is changing in that there are more women in councils than was previously the case. The change creates a positive impact. Women are beginning to have more of a voice in major decisions affecting the community and they provide good role models for the community members. Grass-roots participants stressed the importance of having good role models in local governance, particularly related to substance use.

The dynamics of Band politics have long been a concern among many reserve communities. Sometimes Band politics creates divisions so that there are families who have resources and those who do not. Often, marginalized individuals and families simply fall between the cracks. One participant expressed concern that when an important matter is brought to council, it is not taken seriously unless those presenting it have access to other resources beyond those of Band Council. As a result of this attitude, the community member who brings the concern has to let the issue go unattended or take it on herself on a small scale. Many of the tensions created through Band politics are the result of the Band system itself; i.e., its lack of relationship to traditional ways of governing, and the values of patriarchy and class divisions that came from European society and have been internalized by First Nations people over time. Because these attitudes exist, it is necessary to put checks and balances on both Band and traditional governing systems.

On the positive side, one participant told of a by-law created to stop the illegal sale of substances on the reserve. This sends the message to the community that the leaders value them and will protect them. It sends the message that the leaders will no longer tolerate this standard of behaviour in their community. Another participant told of the hall rental policy of a nearby Wet'suwet'en community. If the hall was being rented by an organization that was sponsoring an event related to health, they were given a special hall rental rate. These initiatives reflect the changing values and beliefs of the community as represented by their leaders.

Building Resources

Without doubt, more development of human resources is required given the many roles that people must play in the community, the new learning that must occur as the transition process unfolds, and the many pressing and immediate problems facing the community. Some staff are untrained, some are trained in the "government way" of doing the work, some resist training and some have a great deal of expertise that is not being used. Many staff need healing as well, and it is difficult to find opportunities to do this with all their other responsibilities. It is difficult to get help for these tasks from the non-native community, given the lack of trust and the need to develop new systems related to traditional ways of thinking and working. A great deal of staff energy is wasted learning about changing government policies and programs, keeping track of the latest funding priorities and personnel outside their community, and dealing with the dynamics of Band politics within the community.

Participants expressed the very strong message that the funds for social development were wholly inadequate. When we heard the small sums allocated for traditional approaches and prevention – activities not emphasized by current government policy – we were appalled. It is no use to tell First Nations people to take over their own services and design them as they wish if the funding allocated is insufficient and already delegated to support non-traditional approaches.

Taking the Next Steps

Respondents had many ideas for change. There is a very important opportunity to take some major steps in reformulating social and health services. As mentioned at the beginning of this chapter, an upcoming bilateral agreement between the province and the Hereditary Chiefs will allow for block funding for health and social services, and presents the opportunity to develop ideas that do not follow non-First Nations ways of thinking about these issues. Wholistic approaches that cut across the usual categories of services, and depend upon culture and traditions could be introduced.

These remain the respondents' opinions about mandatory treatment for women who use substances during their pregnancy. Although this issue was raised by us during our interviews and focus groups, there was no consensus about it. Some people said it was a good idea, some began by expressing favourable ideas and then changed their minds after they thought about it, and others were opposed. Many respondents simply hadn't ever considered it. It seemed like an idea from afar, unrelated to their reality. Given what we learned about community efforts, it seemed that mandatory treatment was simply a "non-starter." There may be ways in tradition and culture where those who are harming themselves and/or others need removal from the community or containment in the Clan House, but to consider how this is done within the context of a caring community and with the support and forgiveness of others is essential. These kinds of actions must emerge from the community members themselves and not be imposed as yet another government policy. Chapter 5 reflects some of the ideas that emerged from the focus groups.

Rather than many recommendations that could be seen as a burden for the community, we decided to present a few ideas that were suggested by the respondents that build on the positive initiatives taking place in the community and that address in a wholistic way the issues of women who use substances during pregnancy.

A Cultural Development Centre

Our respondents indicated that cultural renewal is absolutely essential because it is the anchor for all of the changes occurring in the community and the key to the future. Yet, although many groups support the renewal, no one group has as its sole mission to do so. Given the loss of traditions through laws and practices of the non-Native community, it is essential that government support its retrieval. There needs to be funds for the Gitxsan people to build a cultural renewal process, perhaps to do as some Nations have done, and build a healing centre in the community that symbolizes the culture and its crucial place in community. Here, traditional leaders and Clan Houses could find a place to take on their work of supporting and healing. As one person said:

> …a building controlled by the people themselves, not having to meet other peoples standards versus how we, as First Nations deal with it. Then it might be easier for us to say to a young mom, "Use the family members or the House system to say you're pregnant and [that you] must have support."

A Place for Women

Throughout our interviews, we heard a plea for women to regain their rightful place in Gitxsan society. We learned of many activities that they are undertaking to do so. We heard about the urgency of reaching women who use substances during pregnancy. There needs to be a place for women to talk about their experiences in developing leadership and to plan community responses to the problems affecting women and children so that they have a place on the agenda.

Women in the community have recognized this need and have formed a centre called Wilps Na'ah, governed by a society and funded by the Ministry for Women's Equality. Here First Nations and non-First Nations women have come together to develop with the mission:

- to honour and acknowledge women of the past who have paved the way for us;
- to support and promote the betterment and well-being of the Women of the Upper Skeena; and
- to work to create a safe, self-healing and creative environment for future generations.

Many women were pleased to participate in this research and wanted it to accomplish something useful. It is a beginning, but it should be followed up by community-based research and action. Given that pregnancy and substance use is a gender-specific issue, at least in part, we offer to the women of Wilps Na'ah any assistance that might be useful to them. A participatory action research project from the Centre, shaped and carried out by the women in the community and focused on women who use substances during pregnancy, could build upon the efforts of individual women and create a force for change.

Funds for this research and others by Aboriginal women should be allocated from funding bodies *as a priority and with different criteria than other projects*. It is simply not possible or desirable to expect Aboriginal women to write complicated funding proposals that do not fit their own realities or ways of thinking. It would be far better to ensure that the group has a clear idea of what it wants to do, how it will go about the proposed project and how it will involve others if it needs additional expertise.

A Traditional Gathering: A Gitxsan Think Tank

The community is undergoing tremendous change on many different fronts. Specific groups have been established to accomplish particular aims. Years of struggle have left their mark and it is sometimes difficult to move on from the conflicts that exist in the community. We propose a gathering of all those in the community who wish to form a common vision for the next decade and beyond that cuts across political structures, communities and service systems. This gathering could begin a process whereby the efforts of one group were known and built upon by others. We must save our human resources and work together. We would hope that all Gitxsan people would know about this gathering, not just those who live on the reserve, but also those from far away. The latter are also Gitxsan people who can participate in the changes.

Conclusion

This case study set out to answer three questions: how the Gitxsan people deal with substance use by pregnant women; what they think of present efforts; and what is their view of mandatory treatment. We found it impossible to address any of these questions without analysing the history and its impact on the communities at present. We also found it impossible to address these questions without describing the many political and social issues facing the community as a whole. The challenges confronting First Nations people are often misunderstood because they are not placed within a historical and wholistic framework. This is how prejudice and stigma are perpetuated. Substance use and pregnancy is understood by our respondents as a crucial issue, but one that is connected to many other issues. There must be different responses on many different levels if it is to be tackled. Another clear finding is evident: Gitxsan people have begun the struggle to reclaim their communities. They are saying what many other non-Aboriginal people have come to believe: individual problems such as this cannot be tackled without a whole community response and, at the same time, individuals have the power to make change in themselves and their community.

Gitxsan people are using the resources of treatment for alcohol and drug use, health services and child welfare to address substance use. They are trying to change these services so that they reflect the traditional ways of dealing with individuals and community. This is not easy because of the requirements of the non-Aboriginal funding agencies, primarily government. Although these requirements may encourage First Nations people to take over their own services, the frameworks governing these services are still designed by non-Aboriginal people. The tasks are ever-challenging because at the same time that they are trying to take over their services, Gitxsan people face the considerable immediate needs of the community, and they must reclaim a culture that has been damaged by colonization. Moreover, there are not enough trained and available people to take on the many leadership positions that are required to address all these issues. Within this context, it is not surprising that respondents were very proud of their efforts and successes and, at the same time, gave the strong message that resources, including human resources and sufficient funding, are crucial if these successes are to be continued. The other important finding is how women, often on their own and using their own meagre resources, are trying to make a change for pregnant women and all women in First Nations communities. These efforts must be supported, as they are a community strength.

Government has a role to play in helping to restore what it had a major role in damaging. Canadian citizens need to understand that they also have a role to play in this restoration process. Their attitudes can either help us or maintain the oppression and pay for it in terms of living with the social problems these attitudes help create.

CHAPTER 6: RESPONSES TO SUBSTANCE USE DURING PREGNANCY: ALTERNATIVES AND RECOMMENDATIONS

By Deborah Rutman, Barbara Field, Audrey Lundquist,
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Introduction

In this chapter, we present directions for policy and practice articulated by substance-using women, human service professionals who work with them, and Aboriginal women and community members. We support these approaches and believe it is essential to highlight these too-often muted voices. We also draw special attention to these policy alternatives because we believe that they do not replicate the familiar dichotomies in the current policy discourse.

In the second section of the chapter, we review and respond to the policy alternatives uncovered through our analysis of the Supreme Court decision and the media discourse. We discuss the implications and potential outcomes of these various alternatives.

Finally, we conclude by providing a set of recommendations directed to government and to Status of Women Canada. We submit that these policy recommendations are grounded in the experiences of the people directly affected by the issues, which will help ensure the proposed directions' relevance and ultimate success.

Part I

Directions From Substance-Using Women, Human Service Practitioners and Aboriginal Women

Alternative Ideologies and Attitudes

According to our project's informants, a primary starting point in identifying or envisioning policy or practice responses is the philosophical base of policies and practices. Substance-using women, Aboriginal women, and human service professionals clearly and emphatically spoke of the need for a fundamental shift in the ideologies and societal attitudes relating to (pregnant) women's substance use. This message was echoed in the current relevant policy and practice literature.

Most importantly, ideologies and attitudes need to turn away from their dichotomous framing of the "problem" and "solution" to a more wholistic and humanistic conceptualization. Dichotomous framing – one that pits a woman against her fetus, leads to an all-or-none abstinence-focused approach to treatment and recovery, and entrenches "child-focused" directives in the child welfare system – has had a powerful influence on existing policies and programs, and on the legal and media discourse. However, as has also been demonstrated, policies and programs grounded in dichotomous thinking have had deleterious effects on women and therefore their fetuses.

Shift from Abstinence to a Harm-Reduction Philosophy

A non-dichotomous framing of the issues is exemplified by a harm-reduction approach to working with substance-using pregnant women. Many participants spoke about the importance of shifting to a harm-reduction philosophy and of its positive consequences in practice. As this practitioner told us:

> I think what [the worker] did differently was [that] the expectations from the beginning weren't so rigid. She never presented to the mom: this, this and this. It was just, "I'm worried about you, you are having another baby, you are having trouble taking care of the one you have, you know, what can we do?" It wasn't putting such a burden on her that she had to commit for a lifetime process.

Shift from Child Welfare/Protection Ministry as Adversarial to the Ministry as Supportive

Another ideological shift that reflects a non-dichotomous framing of the issues relates to the place of child welfare practitioners in the treatment of substance-using pregnant women. Child welfare workers need to be part of a supportive, pregnancy outreach team for such women. Clearly, however, child welfare workers' mere presence on this team is not sufficient; they must be working from the same harm-reduction, women-focused philosophical base and be as knowledgeable about women's addictions as their colleagues. Moreover, it must be evident that the intent of having child welfare practitioners involved in women's treatment is to augment women's feelings of power and control over the situation, rather than the reverse:

> [I]f she is going to be involved anyway, let's get her, the social worker, involved prior to the last minute. Find out what it is this person is about. Help the woman turn the tables from being frightened of seeing the social worker and not feeling she has any power. Being able to say to her, "You work for the government, I am going to need your help." That's a very tricky piece but that's the piece that you want to give them in order to turn the tables around. So that they are not the victim of [the government], they are actually being able to ask the government, saying, "I want to keep this baby and this is what I want you to do to help me do that."

Shift from Viewing Child Apprehension as the Failure of an Individual Family to a Failure of the System/Society

Another ideological shift that would reflect non-dichotomous framing is evident in the values underpinning Scottish child welfare policy: in Scotland, a child's apprehension by the state is viewed as a failure of the child welfare system, rather than a failure of an individual parent or family. This philosophical base implies that the state is obligated to try to support the parents in every way possible; also implicit is the notion that providing support to the parent(s) is the best means of supporting the child, and that the parents' and child's interests are linked rather than opposed to one another. Another key implication of this philosophy is that the state has a responsibility in supporting the parent/mother in order to support the child.

Participants felt strongly that adopting the Scottish model in child welfare would have positive consequences for substance-using women and their children. At the same time, they emphasized that such an ideological shift would be dramatic, given current trends in Canadian child welfare policy:

> [I]n Scotland, [the] removal of a child from a family is seen as a failure of the system. Starting from there would be a qualitative shift from our current practice. And it's almost how do we move to that place, where we have done everything that we could to support that mother/child pair, and that if that has to be broken down, then we also look at that critically to say how have we failed, what else could we have done? Knowing that, sometimes of course, it will have to happen, but it better be a last resort, rather than what's becoming a first resort out of fear.

Community Awareness and Education

As was discussed in our case study (Chapter 5), community awareness and education were seen as key prevention strategies. Participants believed that children and youth needed to be informed about the effects of maternal substance use, FAS and FAE, and about reproductive health and birth control. Participants also emphasized the importance of openly discussing the *causes* of (maternal) substance use, particularly within an Aboriginal context. It was hoped and presumed that open community discussion would promote the de-stigmatization of people with addiction problems, and would lead to community action and support for substance-using women:

> [T]he better method is to educate our young people from the start about the long-term effects of FAS. You have to think in terms of the seventh generation. Each of us takes our personal cycle; we're the start of the intervention.
>
> I tell our young people, now I say, don't look at those people as drunk. Sit down and talk to them once in a while. They'll tell you a lot of things that they've been through.

Effective Treatment Approaches – What Works from the Perspective of Women

Effective treatment addresses the barriers that women experience in accessing care. These barriers, as identified by women themselves, include:

- fear of the baby's apprehension by child welfare authorities;
- contradictions between abstinence and harm-reduction approaches;
- contradictions between addictions and child protection ideologies;
- lack of fit between existing treatment options and pregnant women's needs;
- lack of availability of treatment when women seek or need it;
- inflexible rules and inaccessible care;
- unsupportive attitudes of practitioners;
- lack of training for practitioners who could help in accessing care; and
- lack of resources that enable women to get to treatment (e.g., resources for transportation or child care).

As noted previously, these barriers are largely due to disconnections between policies and/or the incongruities in the ideologies that underpin policies. Thus, successfully addressing the barriers will require policy *integration*. Moreover, the integration/harmonization process needs to be informed by a thorough appreciation of how current policies affect women (e.g., for women on social assistance, the threat of losing one's housing while one attends a residential treatment program is an overwhelming barrier to treatment). We recommend that the work of instilling a deep appreciation of women's experiences of policy should be done through a collaborative, multi-sectoral process, in which policy planners, practitioners and women "walk in the shoes of a woman" as she attempts to access treatment.

In addition, participants identified a number of key dimensions of effective treatment approaches. These are:

- treatment programs geared specifically for pregnant women;
- programs/facilities for after care;
- wholistic care;
- outreach;
- residential facilities with home-like environments;
- peer support, counselling and group work;
- non-judgmental attitudes of practitioners and unconditional support; and
- individualized treatment plans made collaboratively with women.

Each of these dimensions will be briefly discussed.

Treatment Programs Geared Specifically for Pregnant Women

There is a pressing need for treatment programs geared for pregnant women. Women spoke of their need for safety, support and understanding in a non-threatening environment; they also spoke of the importance of being with other women who were pregnant and/or parenting, and who had gone through comparable experiences. In addition, participants emphasized that effective treatment for pregnant women included and involved other family and community members:

> It would be great to see more treatment centres for pregnant women and their families so they could get the help that they need around this issue. And basically someone walking that road with them offering them education, guidance, love, understanding, support. Someone helping that individual to find the root of why the abuse is happening.

Programs and Facilities for After Care

As an extension to the above, participants spoke of the tremendous importance of after care. Programs and facilities need to be available to women after their pregnancy, and should offer parenting and other types of support:

> There should be a place that's one half for pregnant women and the other half for moms. There should be doctors who are at both, and nurses and helpers or volunteers [women who are users themselves]. And there should be counsellors for women who don't want to talk mother to mother. That place would be packed.

Wholistic Care

Effective treatment for pregnant women is wholistic and aims to address and support a woman in all areas of her life, including her health, housing, social and spiritual needs. Several participants observed that women's social needs were frequently ignored in treatment programs, even though loneliness and social isolation often contributed to their substance use:

> Maybe live in a centre set up like a home where other women who are in the same situation can live together, and put all the services in that centre, like a counsellor, and treatment and group sessions. Not just the addiction, but other stuff as well, like teaching life skills and career building. Like focus on the positive stuff that will bring the woman up. Deal with other problems other than just the addiction.

> This program has helped me a lot. Loneliness was a big issue before. Not now. I have laughs.

Outreach

Ongoing, supportive outreach is critical to effective care. Numerous participants spoke of the importance of having someone "come looking for you" in order to demonstrate caring and concern, and to provide the message that "you matter" to them. Participants also noted that for substance-addicted women with low self-esteem, it often was difficult to believe that anyone would care; thus, it was crucial that outreach be both persistent yet non-judgmental, and that it meet a woman on her own terms:

> Five years ago, I wouldn't look at you. I was a hard person. I had only three friends. During counselling and in the years of my incarceration, First Nations people came to the jail to sing for mass. That's where I decided to turn: there were people who were willing to come to jail to meet me. They were reaching out to help me and other people like me. They were kind. I didn't see kind people like that in my drinking days.

> It's hard for someone who has low self-esteem to accept the fact that someone cares for them. When you become their friend, you kind of walk with them and hold their hand and support them, and they know that you're there.

> I think home visits would show the woman that you support her, but you wouldn't want to make it seem like it's like welfare or anything where you're being judged but more for support. Like, set up the visits so it works in her schedule. Let her know it's for her that you're there. You're there to support her and help her have a healthy baby.

Residential Facilities with Home-Like Environments

Effective care provides women with options, including the opportunity to receive treatment in a residential environment. Participants spoke of the value of home-like residential care, again geared specifically to pregnant women. Residential treatment can enable women to come together and provide mutual support, as well as learn about and appreciate the physiological process of addiction and the underlying causes for substance use:

> Then I went into the residential treatment centre. When I first went in there I thought I could still use once or twice.... But once I was there, I learned about what the stuff does to you, what it does to your brain. I didn't want to listen. But I did. A week into the residential treatment program, I started to relax. By the time I left there, you could have offered me cocaine, heroin, and I would have said, "I'm going to do anything I can to stay away. Nothing good comes of it." Now, I work so hard to keep sobriety. But it's something that I like to do.
>
> A home where there can be counselling and testing and if they find this mother is still using, then they can admit her to that group home, where you can all sit around like this and talk about why you're doing it. I think that would help. I think we really need that up here in this area. Why can't the government give money for a place like that?

Peer Support, Counselling and Group Work

Peer support has already been discussed in relation to the importance of addressing a woman's social needs. Participants highlighted this point in their discussion of the value of having ex-users be employed as peer counsellors in treatment programs and facilities. Participants felt strongly that peer support and counselling should be empathic, non-judgmental, non-threatening and empowering. Moreover, through peer support, women could contribute to their own and others' healing as role models and mentors. Many women spoke of their desire to help others overcome their addiction problems as soon as they themselves had progressed further in their recovery. Clearly, peer support is a means to both receive and give back to others and thus is a critical dimension of effective care. Peer support and mentoring were also discussed at length as a means to facilitate healing even after a person's participation in a formal treatment program had ended:

> If there's one thing I'd like to see, is to have people who've been there, where I'm in, to counsel me.
>
> If I ever get off this stuff, I want to help those pregnant women. I want to be a support for them.
>
> That comes within our healing journey. I believe that society will heal by being together like this, in groups, and by being and seeing role models.

Non-Judgmental Attitudes of Practitioners and Unconditional Support

Substance-using pregnant women need the unconditional support and compassion of practitioners and peer counsellors. Participants spoke emphatically about how the unsupportive attitudes of professionals can be a barrier to effective treatment, and can even be a prime reason why women avoid treatment altogether. Practitioners need to appreciate the complexities of women's addiction and healing processes; thus, they should not approach a woman's treatment as a "pass/fail" experience. Unconditional support means that women will be "given the benefit of the doubt," that their relapses are not judged, and that their day-to-day accomplishments, however seemingly modest, are celebrated:

> People really need to give the women support. Give them a break, some leeway. Give them a little encouragement.
>
> When I first came here, I was scared. I would have come earlier had I known about it. But I was terrified that I would be judged. But they care; they genuinely care.
>
> G. is my favorite nurse. There was this one time, and I screwed up, and I got really scared – what would this mean for the baby? But G. said, "Don't feel guilty. Your baby's active." That's the kind of people we need. When I come down, it's people like G. I have to talk to.... Before I got here, I wanted to kill myself.

Unconditional support also instils in people a sense of hope, which has been shown to be a major factor that "turns things around" for women with addictions problems (White, 1998).

> A cop did it for me. He showed faith in me. I had no idea he was risking his career at the time by telling me what he did. I was going to marry this guy, and this cop took me into this room and told me he wasn't supposed to do this, but then he handed me a file that was about this man. I had no idea. He had been arrested for all kinds of horrible things. The cop told me that I will make my own decision but at least now I know exactly what I'm getting into. He said he thought I could do better. I had no self-esteem. I thought I was nothing and this cop saw something in me...I ended up in detox and ended up sobering up.

This woman has been sober for more than 10 years and was now a counsellor and support worker for a cultural healing centre.

Individualized Treatment Plans Made Collaboratively with Women

Another dimension of effective treatment, along with practitioners' attitudes, is the way in which professionals work with women to set treatment goals and plans. Plans made collaboratively with women, with goals set by women themselves in recognition of their unique circumstances and needs, are apt to be most effective. A collaborative approach signifies respect for the woman, appreciates her individuality, and empowers her in her relationships with professionals.

> What they should do is have people available to sit down and work out individual plans, one to one, and tailor the treatment to the person. And people have to realize that you're going to slip up....

Note that there are programs in British Columbia and elsewhere in Canada that provide highly effective care and that encompass all or nearly all of the above dimensions. We strongly support the continuation, and where appropriate, the augmentation of these programs, and hope that they will serve as a model for effective, women-focused care throughout the country.

Healing Through Cultural Renewal – What Works from the Perspective of Aboriginal Women

Aboriginal women spoke of the tremendous importance of cultural (re)connection as a means to facilitate healing and support recovery. Native treatment centres, especially those designed for women, were seen as one valuable means to connect women with traditional culture:

> The Recovery House really helped me a lot. It's all First Nations women there. Being there taught me how to have and be a friend. How to respect people. How to teach and ask other people to respect my boundaries.
>
> Why don't they put more native treatment centres all over Canada? They help. They really help!

Another means to help (pregnant) women with serious substance-use problems was through intensive round-the-clock support and, if necessary supervision, focusing on women's connection with culture. This might come about through taking a woman into one's home, accompanying her on errands and activities, all the while attempting to reinstil in her a sense of respect, confidence and pride, and emphasizing that she and her fetus were valued within the community:

> When I was drinking, this family noticed me. They saw I was homeless. They took me into their home. They wouldn't let me into town alone. I never went anywhere unchaperoned. I ended up going with that man's son and having his child – we have a hereditary princess. I went into AA when I was eight months' pregnant. That was a good experience. I wouldn't have chosen it, but it snuck up on me…. Now I ask myself why I am sober. I don't hang out with drinkers. I do a lot of ceremonies. Sweats. That's my way of being clean and sober.
>
> What I know now: if I ever do alcohol and drugs again while I am pregnant, I tell M. that she has full permission to kidnap me…. I believe in the power of "kick-butt" grandmothers. If we had a circle of women here, and if there would be a pregnant woman in the circle, and she's defiant...what's wrong with my taking her to M's house?

At the same time, participants spoke of the significance of cultural reconnection programs and activities that did not necessarily have a treatment focus; these activities promoted healing through the teaching and practice of traditional ways. For many Aboriginal people, (re)connection with traditional culture is instrumental to healing, as it instils and/or restores feelings of self-respect, pride and identity that may have been all but extinguished. The following comments by participants speak to the overwhelming value of reconnection with culture and tradition for Aboriginal women, many of whom had successfully addressed their substance addiction:

> When I quit drinking I started homemaking the following year and I'm just learning about our culture from the elders...I couldn't wait to just run to this house and clean up for an hour and then visit for an hour. It just made my day. See, because I was so ignorant of the facts of our culture.... It was just unreal to hear first-hand from the elders and practice this and that.
>
> I used to think I was a terrible addict. Now I say to myself, "Wow, you can sew moccasins!"
>
> Grandma M. was teaching this class, making moccasins and trinkets. I feel really proud of myself, that I can say I make things. I can go to powwows and say, "I made these myself." I tell everyone I know, "There's a class where you can learn things like this." It does so much for you and for your kids. They're learning and don't even know it. I'm so proud of my daughter. We just went to a powwow and she danced, and spoke with a microphone to over 600 people.... I've been really involved with my daughter's school.... The teacher asked me about traditional teachings that I had learned. I talked for one hour. I was so proud to be answering those questions. I didn't think that I knew that much. But I could show what I made, and made for these kids. It's so nice to be proud of who you are and where you come from. This class has done so much for me.
>
> Even though we're in the city, I still teach my children. People in the city are so hungry to learn their culture.
>
> [I]t's really beneficial for the kids to be exposed to those kinds of cultural things because growing up without identify really hurts. It took me until I was 25 years old to realize that, to be proud that I can talk the Okanagan language, that I know canning....

As is evident from these comments, as well as being a key to recovery, connecting with traditional culture can be a means to *preventing* substance use among Aboriginal people, especially youth. In discussing their participation in cultural activities, participants spoke of their role as learners and also as teachers of younger generations. Participants clearly took pride in their work as mentors and appreciated the healing effects of mentoring for both themselves and their "students." Many participants viewed their culture as a source of tremendous strength and as a means to instil pride in young people, which in turn could serve to insulate youth from the pressures and challenges that lead many to substance use and addiction.

Supporting Aboriginal Women to Take Leadership Roles Within Communities

Our case study found that women in Aboriginal communities often assume responsibility for responding to the varied needs of community members, but that this is done informally, as an add-on to women's other work and family responsibilities, on extremely limited resources. In addition, although Aboriginal women's participation in local decision making varies by community, women's formal role in decision making tends not to reflect their tremendous activity as community caregivers, organizers and change agents. In order to recognize the role of women, it is essential to develop ways to strengthen women's capacities and opportunities to assume leadership roles in their own communities. Participants felt strongly that resources for infrastructure development were needed in order to support Aboriginal women's leadership efforts and activities.

Alternative Policy Development Processes

As noted above, innovative and effective women-centred programs exist in Canada. Here we profile three such programs. We discuss the aims and services offered, how they came to be, their demonstrated outcomes to date, and the elements that were seen to be crucial to their success.

The Sheway Project – Downtown East Side, Vancouver

Sheway is an outreach program designed specifically for pregnant women and women with young children. Its purpose is to:

- reduce the number of babies born with FAS and Neonatal Abstinence Syndrome (NAS);
- reduce the number of child apprehensions from mothers in the downtown east side of Vancouver, Sheway's local neighbourhood;
- enable pregnant substance-using women to access prenatal and postnatal care more easily in a setting that is comfortable to them;
- provide positive parent support regardless of whether infants are substance-exposed; and
- reduce the harm to the mother and her infant caused by substance use.

Sheway's staff work from a women-centred, harm-reduction approach. Services are offered on both an outreach and a drop-in basis, five days a week. Women are offered medical care, nutritional counselling, emotional counselling and support, alcohol and drug treatment, assistance in finding safe housing, infant development support and a daily hot lunch. Practical things such as vitamins, clothes, toys and food are also offered. Staff include a community health nurse, a dietician, an infant development consultant, one outreach HIV worker, two Ministry for Children and Families social workers, a part-time alcohol and drug counsellor, and midwives. There are also weekly physician visits and twice-weekly access to an FAS assessment team from Sunnyhill Health Centre.

This inter-agency project, involving the Vancouver Native Health Society, the Vancouver Health Board, the Ministry for Children and Families (Child Protection, Alcohol and Drug Programs) and the YWCA, Crabtree Corner FAS/NAS Prevention Project, Oak Tree Clinic, began in 1993 after census tract information showed that in the downtown east side of Vancouver, 46 percent were alcohol- and/or drug-exposed and between 80 percent to 100 percent of these babies were apprehended following birth.

Outcomes to Date

The following information is from 1996:

- 75 percent of the women remain in the program until delivery;

- one month after delivery, 76 percent of the mothers still have their children living with them, 32 percent are breastfeeding their babies and 20 percent have had their children apprehended; and
- 80 percent of the children are up-to-date with immunizations.

Elements Critical for Success

Sheway works effectively from a multidisciplinary/multi-agency model. It is well located for easy access, provides one-stop shopping and staff has time to build relationships with the women and each other. The combination of drop-in and outreach services, and the philosophical approach of the staff, work effectively for this specific client group.

Breaking the Cycle – Toronto

Breaking the Cycle is an early intervention and prevention program designed to serve substance-using pregnant and parenting women who have young children and who are living close to the street in an unstable environment. It was designed with the principles and priorities of the Community Action Plan for Children (CAP-C) in mind. Its desired outcomes are to:

- reduce the incidence of low-birth-weight babies;
- reduce the incidence of child abuse;
- increase support for parents and increase their capacity for relationships with their children;
- increase partnerships collaborations among agencies and families;
- increase public recognition of the issues and increase resources available to address the problems;
- increase the knowledge and capacity of families and communities through empowerment; and
- increase the accessibility of culturally and linguistically sensitive programming.

Breaking the Cycle operates from a family-centred approach that aims to have agencies adapt to families, rather than have families adapt to agencies. This program offers a one-stop model at which women can receive integrated assistance with parenting, addiction issues and child development services. Their basic needs are supported by a clothing exchange, daily lunch program and transportation assistance. Counselling for mental health needs is available, as are health services such as prenatal and post-natal counselling and pediatric services. Staff are from six partner agencies and include addiction counsellors, public health nurses, infant development specialists, mental health counsellors, and nursing and medical staff.

Following an addiction conference in 1992, which explored the theme of partnership and collaboration, four agencies (women's addiction services, child and family develpment, child welfare and health care) developed a proposal for CAP-C funding. The model for the program was developed as a result of an intensive consultation with numerous stakeholders, including women who might potentially become clients, to determine the most responsive and effective model with which to deliver services. It is described as a collaborative community-based response led by a partnership that includes clients.

Outcomes to Date

The following information is from February 1998:

- almost one quarter of the women who access the services are pregnant – a number viewed as significant, given the difficult-to-reach nature of this client population;
- the outreach component is effective, as there are a consistent number of new women connecting with the service each month; and
- parenting skills have increased and risks to children decreased.

Elements Critical to Success

Breaking the Cycle's improved access to services through its one-stop, coordinated model has been viewed as key to its success. Including families in program design and ongoing evaluation have also assisted it develop in a manner that feels safe to women and their children. The outreach component is key to early connections with pregnant women.

FAS Community Collaborative Network – Prince George

The Prince George FAS Community Collaborative Network is a broad coalition of community members dedicated to effectively addressing the issue of FAS in their community through community participation, identification and transformation. It is not a funded service, but the collective vision of this coalition has bound them together in this 10-year journey. They have undertaken numerous community initiatives, brought many groups together across the community to increase their collective understanding of the issues, and have been committed to including diverse populations within the process:

> Lack of money is sometimes seen as empowering. The strategies that the Network and its antecedent organizations chose were based on their own criteria and not those of a program funding criteria. It gave the group flexibility in decision making, and in the timing of the strategies they took (Prince George FAS Community Collaborative Network, 1998, p. 74).

The Network is not philosophically homogenous, as some members embrace a medical model that focuses primarily on the individual, while others favour a harm-reduction approach. Decisions have been made by consensus, and in that discussion process, "disparate disciplines" have been moving closer to reaching common ground on issues. From January to April 1998, they engaged in a participatory action research project to "develop a process of soliciting and developing prevention strategies and prevention policies on FAS and FAE by the people most affected by the policies" (ibid., p. 140). Overall, they found evidence that policy emerging from consultations and partnerships, such as the one they developed, have a greater potential for success than policy developed in isolation from the communities they are designed to serve (ibid).

Although this brief profile cannot begin to describe the work this Network has accomplished over the years, the key purpose for including it here was to illustrate a policy-making process that is different from most. It will be important to track this initiative over time, as there will be interesting lessons for all as this community addresses FAS prevention.

Part II

Directions from the Supreme Court Decision

Supreme Court Majority Judgment

Although there is considerable ambiguity regarding the Majority's "solution" to the problem of substance use during pregnancy, a legislative approach is raised repeatedly throughout the decision as a policy alternative. Indeed, in view of the frequency with which it is proposed (despite the preface's statement, "if anything is to be done...."), it seems reasonable to conclude that legislative review and reform is the Majority's principal solution to the problem of substance use during pregnancy. The Majority's stated rationale for recommending legislative reform is that this approach directs the issue back to elected politicians to decide the matter; it is presumed that these politicians have accountability to their constituencies via the democratic process, and thus that the outcome of the legislative process will reflect the public will.

Our Response

The Majority's recommendation of a legislative solution reinforces the idea that a legal response to this social problem is appropriate. Our project's findings, as well as those from the practice and policy literature, strongly indicate otherwise. As well, we have strong concerns about channeling limited public resources into costly legal mechanisms that come, inevitably, at the expense of non-legal responses; instead, we advocate non-legal approaches which, we maintain, will more effectively address the social and health issues at the core of the problem.

In addition, the Majority's "solution" is a political one, and although there is an implicit assumption that elected politicians will somehow engage the public in discussions to inform the legislative policy-making process, there is nothing to ensure that multiple sectors within communities will have direct access to and involvement in the policy-making process. What is crucial here is the connection between the public debate and the policy-making process. What is needed are extended public discussion processes, through which consciousness raising, debate and consensus building on the issues associated with substance use during pregnancy will occur. Moreover, we submit that such round table discussions need to clearly underpin the policy development process; this will help to ensure that there is increased accountability and local responsiveness. These ongoing discussions need to involve multiple constituencies and, in particular, women and community members who have direct experience with battling substance use during pregnancy.

Supreme Court Minority Judgment

The Supreme Court Minority judgment argued that, prior to birth, a fetus is a viable living entity; as such, its personhood needs to be recognized morally and in law. The Minority bases this argument largely on demonstrated advances in medical science and imaging technology. Moreover, the Minority uses this argument to advocate that the fetus should have a legal right to protection from harm, in the same way and to the same extent that children and others are entitled to legal protection. The Minority proposes that, in the case of the fetus, serious harm that is linked to maternal substance use should be addressed by legal measures, through mandatory treatment and/or confinement, if necessary.

Our Response

We support the idea that the fetus is a living entity and believe that the state, the corporate/private sector, communities, families and parents have responsibility to promote healthy fetal development. Moreover, our findings indicate that pregnant women, even those who use substances during pregnancy, are deeply concerned about their fetus' health and proper development. For some women with addictions problems, seeing "pictures" of their fetus through ultrasound technology strengthens their connection to the fetus and consequently supports their efforts to reduce or abstain from substance use.

At the same time, we feel strongly that granting fetal rights is ultimately counter-productive to society's goal of ensuring healthy fetal development and preventing fetal harm because of maternal substance use. As we have seen from the Supreme Court decision and the associated media discourse, the language of rights inevitably leads to a dichotomous framing of the issues which becomes highly adversarial and ineffective as a response to the problem.

Furthermore, in response to the Minority's "solution" of mandatory treatment/confinement, our project's findings indicate that this is not an appropriate policy direction in Canada for a number of reasons. These include:

- The evidence is overwhelming that blaming and shaming individual women for their substance use and addiction problems do not work. Indeed, social reprobation and stigmatization accelerate downward cycles, and hamper healing and recovery.

- Designing and implementing mechanisms for mandatory treatment/confinement would consume precious public resources that more appropriately ought to be dedicated toward community-based prevention initiatives, particularly those that are underpinned by a harm-reduction philosophy. Our experience in child welfare tells us that the creation of legislation/policy to deal with "worst case scenarios" inevitably will drive the entire system and siphon off resources that may be more profitably allocated toward family support and prevention.

- Mandatory treatment/confinement reproduces and reinforces the oppression that contributes to women's substance use in the first place. Aboriginal communities will be particularly adversely affected by the implementation of mandatory treatment/confinement.

- Good policy cannot be made in a knowledge vacuum. There is currently a dearth of knowledge about the life experiences of "those women" who use substances during pregnancy. This project is one of only a small handful in Canada that gives voice to substance-using women, and which explores and appreciates the social, cultural and historical context in which their substance use must be understood. In addition, as McCormack (1998) reminds us, scientific knowledge is still incomplete in relation to the likelihood, nature and irreparability of the fetal harm ensuing from maternal substance use. In view of this, policy development in this area should not be made without more complete and grounded information.

- Mandatory treatment/confinement singles out and punishes individual women, without recognizing our collective, societal responsibility to promote and ensure healthy fetal development. As a society, Canada consistently has endorsed and upheld the value of collective responsibility for citizens' well-being.

Recommendations

1. We recommend that federally funded community-driven initiatives such as CAP-C be continued and expanded in order to ensure local projects' continuity and to increase the number of community-based projects and programs that respond to local needs. Moreover, at the point that the evaluation of CAP-C projects is completed, we recommend that successful programs be showcased nationally so that communities can learn from and build upon one another's experiences and accomplishments.

2. We recommend that federal resources be allocated to establish and provide infrastructure support to local/provincial "Policy Round Tables." These Tables would serve to promote public awareness of the multiple and complex issues connected to substance use during pregnancy, and would aim to identify a set of "common ground" principles that in turn would underpin comprehensive policy development in this area. Key attributes of these Tables include:

    Collaborative: involve multiple sectors and stakeholders, including substance-using women and their families, Aboriginal women and community members, and front-line human service practitioners. In addition, multiple levels of government (i.e., federal, provincial and local funders/policy-makers) should participate in the Round Tables, as should the corporate sector, which needs to signify its recognition of responsibility as community citizens.

    Locally focused: with "local" defined flexibly, as the community, municipality, region, Band or nation.

    Ongoing: in recognition of the evolving and long-term nature of the process.

    Wholistic: examine the issues of substance use during pregnancy in the context of a women's life.

   The work of implementing and operating these Policy Round Tables may be informed by existing participatory dispute analysis/resolution frameworks (see Owen, 1998).

   As an initial component of their work, we recommend that these Policy Round Tables audit existing provincial/local resources for pregnant/parenting women who use substances. This will identify the barriers and enablers to effective treatment and therefore help develop appropriate policies and approaches.

3. We recommend that the federal government allocate resources to strengthen the capacity of traditionally marginalized constituencies – in particular, Aboriginal communities – to participate with a strong voice at the Policy Round Tables. In addition, we recommend that federal funds be allocated for grass-roots communities to create the infrastructure needed to implement the directions of the Policy Round Tables.

4. Given the traditional Aboriginal world view that caring for mothers and children is a community responsibility, there is considerable potential to learn from Aboriginal people about ways to

support substance-using pregnant women within a community context. Our experience in undertaking this project reinforces our view that participatory action research is a valuable means to invigorate communities and to increase awareness and action in relation to critical social issues.

We therefore recommend that government allocate funding for participatory action research in Aboriginal communities, and that this research be overseen and undertaken by Aboriginal people. Moreover, we recommend that Status of Women Canada make the funding of participatory action research in Aboriginal communities a high priority in its research agenda.

In resourcing this research, there needs to be an appreciation that participatory action research takes more time than other kinds of research, and that the research processes, products and outcomes cannot be determined in advance; thus, funders' flexibility is essential.

5. Participants spoke clearly about existing barriers to treatment and recovery, and they identified numerous critical dimensions of effective care and support. Participants' ideas constitute a body of recommendations for policy and practice that we fully endorse. Specifically, however, it is important to underscore three interrelated recommendations that emerged from participants' messages:

   - That government ensures that adequate resources for *women-focused* alcohol and drug treatment programs are available. This will require the creation of additional treatment programs, specifically those that are geared to pregnant women and that incorporate the above dimensions of effective care;
   - That, through the ongoing Policy Round Table process, disconnections and incongruities in existing policies and approaches are identified and addressed; and
   - That health promotion and harm-reduction philosophies be the starting point for policy discussions and proposed remedies in relation to pregnant women who use substances. This philosophical orientation should promote attitude shifts for all stakeholders working with substance-using pregnant women and assist in finding common ground

6. Finally, we strongly recommend that government place a moratorium on legislating policy that allows for mandatory treatment/confinement for pregnant women who use substances. This moratium should be in effect until all other options, particularly those recommended here, have been exercised and evaluated.

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  Jill Vickers and L. Pauline Rankin

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  Marilyn Callahan, Barbara Field, Suzanne Jackson, Audrey Lundquist and Deborah Rutman

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* Some of these papers are still in progress and not all titles are finalized.